Mr Ian Breeze

A Report by the

Health and Disability Commissioner

(Case 03HDC18813)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer/Complainant
Mr Ian Breeze	Provider, general surgeon
Norfolk Hospital	Provider, private hospital
Dr B	General practitioner
Dr C	Anaesthetist
Mr D	General surgeon
Dr E	General practitioner
Dr F	Registrar

Complaint

On 11 December 2003 the Commissioner received a complaint from Mr A about the care and treatment he received from Mr Ian Breeze. An investigation was commenced on 18 December 2003, as part of a Commissioner initiated inquiry into the quality of care provided by Mr Ian Breeze to a number of patients on whom he performed surgery. The issue the Commissioner investigated was:

- *Whether Mr Breeze provided services of an appropriate standard to Mr A, on whom he performed a repair of hernia operation at Norfolk Hospital in August 2000, and who developed subsequent complications.*

Information reviewed

- Letter of complaint from Mr A, received 11 December 2003
- Transcript of interview with Mr A on 2 March 2004
- Response to the complaint from Mr Breeze, dated 9 February 2004
- Mr A's medical records from Norfolk Hospital
- Mr A's medical records from a public hospital
- Mr A's general practitioner records
- Information from Dr B , Mr A's general practitioner
- Information from Dr C, anaesthetist
- Information and medical records from Mr D, general surgeon
- Letters from Mr A, dated 13 July 2004 and 26 October 2004
- Mr Breeze's response to the provisional opinion, dated 4 August 2004
- Additional information from Mr Breeze, dated 27 October 2004

Independent expert advice was obtained from Mr Mischel Neill, general surgeon.

Names (other than Mr Breeze, the Commissioner's expert advisor and the hospitals) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information gathered during investigation

Pre-surgery
On 11 August 2000 Mr A consulted Dr E, general practitioner at a town's medical centre, to obtain a prescription for gout pills (his usual GP at the medical centre was Dr B). During the consultation, Mr A showed Dr E a lump in his groin. Dr E informed Mr A that he had a hernia. Dr E's attempt to push the hernia back in was painful and unsuccessful. Following the consultation, Dr E faxed a referral to Mr Breeze, stating:

> "I'd appreciate your review of [Mr A] who appears to have an incarcerated L inguinal hernia. [Mr A] noted this incidentally a 1/12 ago … This has not been symptomatic, and examination was otherwise unremarkable."

Mr A consulted Mr Breeze on 15 August 2000. Mr Breeze's examination revealed a tender, small to moderate sized, incarcerated left inguinal hernia. Mr Breeze noted that there was no right inguinal hernia and general neck and abdominal examination was otherwise unremarkable. Mr Breeze recommended a left inguinal hernia repair. Mr A elected to expedite surgery by having the operation performed privately at Norfolk Hospital.

The operation
A left inguinal hernia repair operation was performed at Norfolk Hospital on 23 August 2000. The surgeon was Mr Breeze and the anaesthetist was Dr C. Mr Breeze advised that at the time of the operation the hernia was no longer incarcerated. He repaired the hernia using the "Liechtenstein technique", which is "currently favoured and widely practised". The operation note recorded:

> "Indications: Recent incarcerated left inguinal hernia currently reduced.
>
> **Procedure:** Thromboprophylaxis with intermittent calf compression, antibiotic prophylaxis with Gentamycin 5mg/kg, pre-emptive analgesia with a Marcain wound infiltration. Skin crease incision left groin deepened through subcutaneous tissue and external oblique opened in continuity with the superficial ring. Dissection within the cord revealed there was no indirect sac. A small direct sac was present well medially in the posterior wall. This was inverted with a 2/0 Prolene suture. This was reinforced with a patch of polypropylene mesh which was split laterally to 'fish-tail' around the emerging cord at the deep ring. It was sutured at its periphery with continuous 2/0 Prolene, taking care to avoid entrapment neuropathy. The wound was then closed with Dexon to external oblique, subcutaneous and subcuticular layers.
>
> **Post-op:** Review tomorrow regarding discharge."

Dr C could not recall any surgical concerns during the hernia repair procedure.

Postoperative care and treatment – inpatient care
Mr A was returned to the ward at 1pm, awake and comfortable with stable observations. At 10pm it was noted that his observations were stable, he was tolerating food and fluids, and his dressing was dry and intact.

On 24 August it was noted that Mr A had slept soundly, refused analgesia, and his wound was intact. Mr A was discharged on 24 August, and an appointment was made for him to be reviewed by Mr Breeze in the Outpatient Department on 4 September.

Postoperative condition
Mr A advised that within one day of his discharge, both his legs became swollen, his genital area turned black/purple, and his groin was swollen. Mr A stated that his groin was extremely painful, and he was unable to walk. He contacted his GP. He cannot recall his discussions with his GP, and there is no record of an appointment or telephone call with his GP at that time. However, he waited to see Mr Breeze at the pre-arranged outpatient appointment on 4 September.

Outpatient consultation – 4 September 2000
Mr A saw Mr Breeze at the Outpatient Department on 4 September 2000. Mr A recalled that by then his groin was black and his genital area was very swollen. His legs were swollen and black, and he had difficulty walking. Mr Breeze examined him, but his groin and upper legs were too swollen and sore to be touched. Mr A recalled that Mr Breeze informed him that his presentation was normal.

Mr Breeze advised me, and recorded in his letter to Mr A's GP, that during the appointment he noted some low-grade superficial cellulitis (inflammation) involving the medial aspect of the wound and associated swelling, but Mr A was afebrile and otherwise well. Mr Breeze prescribed flucloxacillin for the cellulitis. Mr Breeze advised the GP that Mr A felt that the day after his surgery the lump was still present. However, the area was too sore and swollen to be examined during the appointment. Mr Breeze reassured Mr A that his hernia had been repaired and any residual lump must be something completely incidental such as a lipoma.[1]

Mr Breeze advised me that a minor degree of swelling is inevitable after hernia surgery, and there is also often minor bruising. He recalled that in Mr A's case the bruising and swelling were unexceptional, and Mr A did not inform him of an adverse response of excessive swelling and bruising. Mr Breeze further noted, "Certainly if any mention of that were made, it was not an aspect of any significance and could only have been made in passing. Otherwise I would have noted this as an adverse post-surgical reaction."

Mr Breeze arranged to see Mr A in October, with a view to referring him for an ultrasound if necessary.

[1] A lipoma is a common benign tumour composed of well-differentiated fat cells.

Mr A's condition subsequently deteriorated – his temperature rose, and he became weak and had difficulty moving about. Mr A recalled that the black colour in his groin spread down his leg, and the calf muscle in his left leg became quite swollen and discoloured. He remained badly swollen in the penis and groin area, and the skin on his hands and feet started peeling.

Consultation with general practitioner – 13 September 2000
Mr A consulted his general practitioner, Dr B, on 13 September 2000. Dr B recorded that Mr A's swollen legs were a chronic problem, and "worse 3 weeks since Left inguinal hernia repair". Dr B noted that Mr A's hernia wound was infected and prescribed Synermox (a broad-spectrum antibiotic), Indocid (a non-steroidal anti-inflammatory analgesic, for his gout), and frusemide (a diuretic).

Outpatient consultation – 27 October 2000
On 27 October 2000 Mr A saw Mr Breeze, as planned. There are no notes of the consultation, but Mr Breeze advised that Mr A was "convinced the lump persisted", and so referred him for an ultrasound. The ultrasound report stated:

> "CLINICAL: Left hernia repair. Tubular swelling inferior to the inguinal hernia repair ? Lipoma.
>
> REPORT: Ultrasound examination of the inguinal hernia excision site showed no abnormality. In particular no abnormality is seen at the site of focal tenderness. The tubular swelling inferior to the wound corresponds to prominent slightly hypoechoic lobules of fat aligned in a somewhat tubular fashion with the spermatic cord vessels lying superomedial to this. The fatty tissue in this area is quite tense and not readily compressible. At least one thrombosed vein is noted within the lower spermatic cord region although normal arterial signal and venous signal can be demonstrated. Normal appearing lymph nodes are noted in the left groin region also.
>
> COMMENT: Appearances suggest the palpable swelling is secondary to fatty tissue. This is not as normally compressible as seen and raises the possibility of either an area of ischemic fat or possibly congested fat as a result of some impairment of venous drainage. No other finding of note, in particular, the left testis was unremarkable."

There is no record of any follow-up with Mr Breeze following the ultrasound.

Mr A recalled that in the following months he remained in pain, although the swelling subsided slightly. A lump was noticeable in the genital area, which was "much larger" than the original hernia and very sensitive to touch. A gland in this area was also very sensitive to touch, and he was unable to sit erect. In addition, he had pain in his lower left stomach, which sometimes went into spasms, and caused impotence.

Consultation with general practitioner – 14 December 2000
Mr A consulted Dr B on 14 December 2000. The consultation notes record:

> "Unwell following Left inguinal hernia repair – fatigue, impotence, poor flow.
>
> o/e [genital atrophy], PR examination not done, weight 110kg, blood pressure 120/75.
>
> diagnosis ? etoh [ethanol (alcohol)] ? surgical complication but why [atrophy]. Note large haematoma.
>
> investigations FSH/LH – testosterone liver function tests psa
>
> treatment Frusemide 40mg ½-1 daily.
>
> review 2 weeks."

Further consultation with general practitioner – 29 December 2000
Mr A consulted Dr B again on 29 December 2000. The consultation notes record:

> "Intermittent pain in scar, [impotence] – [genial atrophy following swelling], etoh 6 handles 2-3 times per week, liver function tests raised …
>
> Stop etoh, repeat liver function tests, thrombophillia screen 3 [months]. Breeze."

On 4 January 2001 Dr B referred Mr A back to Mr Breeze. His referral letter stated:

> "Thank you for seeing [Mr A] again. You will recall this chap had a left inguinal hernia repair carried out at Norfolk Hospital on 23/8/2000 and that post-operatively he had a wound infection with cellulitis and as I understand it a fairly sizeable haematoma. I saw him for a review on 14/12/2000 when he was concerned about persisting impotence since his surgery associated with some decrease in [genital size]. He is aware of some intermittent pain over the wound site itself, but this is certainly not persistent …
>
> Examination shows some right [genital] atrophy but the wound itself looks fine with no sign of any recurrence. I enclose copies of his recent blood tests. […]
>
> I am not sure whether sexual dysfunction is a result of his lifestyle … or whether there may be some surgical complication such as venous impairment. I enclose a copy of the ultrasound scan done on 27/10/2000 and wonder if this bears repeating. I would be grateful for your reassessment of [him]."

Consultation with Mr Breeze – 1 March 2001
On 1 March 2001 Mr A consulted Mr Breeze.

Mr A said that he told Mr Breeze all about his pain. At the time he was experiencing dull pain on the left side of his body, with the area just above the scar the most painful. He recalled that most of the area around the scar was sensitive to touch, and that so long as he

did not overexert himself, the pain (which felt like a sharp object inside his left side) did not worsen. The more movement he tried, the worse the pain. The pain wore Mr A down and he was always tired. Mr A advised me that at the consultation he gave Mr Breeze a two-page letter detailing in chronological order the events that had transpired since the hernia operation – the swelling, discolouration, continual groin pain, impotence and night sweating – and stating that he was "living hell".

Mr Breeze did not recall Mr A giving him a letter at the consultation. He said that if he had been given a letter describing multiple problems he would have documented it on his computer and written to Mr A's general practitioner about the problems. Mr Breeze stated that his routine practice was to retain in his filing cabinet all letters received from patients. During my investigation Mr Breeze rechecked his filing cabinet and did not find a letter from Mr A.

Mr Breeze advised me that the consultation on 1 March 2001 was simply for impotence. He recalled that during the consultation Mr A did not mention ongoing pain. In Mr Breeze's view, there was no suggestion that Mr A had ongoing pain at the time because:

1. postoperative haematoma is a self-limiting problem, and would not have caused Mr A's pain over six months after surgery. Mr A's ultrasound scan on 27 October 2000 did not identify a residual haematoma suggesting that he was suffering ongoing pain;

2. the reported presence of intermittent pain in the scar on 29 December 2000 does not confirm that pain was still present on 1 March 2001;

3. when read in its entirety, Dr B's referral letter, dated 4 January 2001, was for impotence; and

4. Mr A defaulted on follow-up appointments.

On examination Mr Breeze noted that the inguinal hernia repair was sound and could not find anything out of order. Mr Breeze advised that he developed a treatment plan in accordance with the complaint of impotence. Specifically, he referred Mr A to a private men's clinic, and prescribed Viagra. In his letter of referral to the clinic, Mr Breeze noted Mr A's hernia operation, and that following the operation there was the "normal degree of post-operative bruising and a superficial skin infection". He noted that Mr A also had a peculiar area of subcutaneous thickening in the inguinal region, unrelated to his hernia, which appeared to be a lipoma. He stated that his left inguinal hernia repair was sound. Mr A advised that following this consultation he was "so disappointed" he did not visit the clinic, nor did he consult Mr Breeze again.

Dr B informed me:

> "From my recollection of events over 3 years ago the wound haematoma [and genital] swelling was significant [and] much greater than I would have expected from this type of surgery. [Mr A] complained early on of problems regarding his hernia repair … [Mr

> A's] job did involve considerable standing and he was overweight – both these factors may have had some bearing on his complications. Overall my impression was that the symptoms [Mr A] suffered were a direct result of surgical complications from his original Left inguinal hernia repair."

Subsequent care and treatment
Mr A advised me that his pain continued. He could manage to get around and do a little bit, but as soon as he got overtired or run down, he simply could not get out of bed.

In mid-2001, at Mr A's request, Dr B referred Mr A to Dr D for his continuing severe left groin pain.

On 17 July 2001 Mr A consulted Mr D. Following the consultation, Mr D wrote to Dr B, and stated:

> "Post operatively [Mr A] appeared to develop a significant infection and said his [genital area was] massively swollen. He did not settle with antibiotics … The swelling gradually resolved but he was left with pain in the left groin. He saw Ian and stated that he felt something was digging in to him, but had an U/S scan which revealed no significant abnormality …
>
> The ongoing groin pain tends to be constant 3/10 but occasionally he has exacerbations 7/10. Recently whilst shovelling he was doubled over with groin pain …
>
> … There is no sign of a recurrent left inguinal hernia but there is a tender thickening adjacent to the superficial inguinal ring. The whole area, particularly on the pubic tubercle was extremely tender to palpation."

Dr D decided to trial Mr A on Voltaren with a view (depending on the response) to infiltrating the tender site around the left pubic tubercle with Kenacort A40/LA. If there was still no improvement, he planned to explore/excise the mesh and remove all non- absorbable suture material. Dr D advised Dr B that Mr A was for "Review one month, sooner PRN". Mr A did not return to see Dr D for the recommended follow-up. Dr D was not sure why Mr A did not consult him again. Mr A did not advise me why he did not consult Dr D again.

Mr A said that for the following two years he "just put up with it" and decided to "live within the cards that [were dealt him]". He experienced pain every day. He was not able to sleep on his left side or work because of the pain, and had to sell his business. He also became tired quickly and moved more slowly.

Readmission to hospital – June 2003
Following a consultation with Dr B on 6 June 2003, Mr A was referred to a public hospital. The letter of referral noted that Mr A had suffered from recurrent problems with pain in his left groin since his hernia repair in August 2000, with cellulitis postoperatively. The previous day he had been doing physical work, and had woken at 11pm with severe pain in his left groin radiating to the left iliac fossa. It was noted that shortly afterwards Mr A had

developed rigors and nausea, and had diarrhoea. Dr B recorded that, on examination, Mr A had swelling in his left inguinal region and slight tenderness in the left iliac fossa. Mr A was admitted to hospital under the care of Dr D with left groin pain and swelling, associated with nausea and diarrhoea. Mr A recalled that he had severe pain spasms in his lower left groin, and was shaking and sweating.

Mr A was febrile on admission, with a temperature of 38.5 degrees. He was given intravenous fluids and intravenous antibiotics. During his admission, he reported pain and swelling similar to that following his hernia repair. Mr A had a chest X-ray, which was normal, and an abdominal X-ray. The abdominal X-ray report noted that there was a "relative paucity of gas within the central left abdomen, which was possibly filled with fluid filled loops of bowel". Mr A was discharged on 7 June 2003, with a diagnosis of "? Diverticulitis", a prescription for Augmentin, and an outpatient appointment with Mr D.

Subsequent investigations
On 3 July 2003 Mr A had a barium enema, performed by Mr D, which showed no abnormalities.

A left groin ultrasound on 7 August 2003 found:

> "In the area of concern, a vague area of sonographically fatty echotexture is seen which does partially compress. No hernia per se is identified. A solitary enlarged lymph node of 1.7cm x 0.5cm x 2.5cm is seen in the left inguinal region with several smaller nodes also noted. Valsalva manoeuvre is performed with no change in left groin appearances.
>
> CONCLUSION: No inguinal hernia detected. Appearances may represent post operative change although the possibility of an unusual lipoma of the cord could be considered should symptoms persist or worsen. This would be a somewhat unusual presentation for this entity, however."

On 28 November 2003 Mr A was seen by Mr D. Mr D noted that the barium enema and ultrasound scan of the left groin showed no specific abnormality, despite the constant pain in Mr A's left groin since his hernia operation by Mr Breeze in August 2000. He stated:

> "On palpation he appeared to experience agonising pain in the groin although he rated the symptoms 7-8/10 on a pain scale. [His] reaction suggested that the symptoms were much greater than this.
>
> Interestingly there is quite a marked asymmetry in the appearance of the groin and I thought that despite the U/S findings he had developed a recurrent hernia. Clinically, however, the hernia repair is intact. The spermatic cords and testicles were unremarkable to palpation. There was no tenderness. He was however, extremely tender to palpation around the pubic tubercle extending down over the femoral canal and also more proximally through the superficial inguinal ring. After full discussion the area was infiltrated with Depo Medrol 40mgs/Lidocaine and I have arranged to see him again in two months time. If there is no improvement then I think he is going to require an

exploration left inguinal canal removal of all non absorbable sutures, ? remove the mesh."

Complaint to HDC – December 2003
On 11 December 2003 Mr A complained to the Health and Disability Commissioner about the care and treatment he received from Mr Breeze. An investigation was commenced on 18 December 2003.

Registrar review – 23 January 2004
Mr A was reviewed by Mr D's registrar, Dr F, at the Outpatient Department on 23 January 2004. Dr F noted that Mr A was still in significant discomfort, and the Depo-medrol injection had not helped his symptoms. Dr F noted that Mr A's pain started around his deep ring and radiated down. Dr F also noted a palpable lump, which was previously thought to be a lipoma of the cord. Mr A indicated his wish for the wound to be surgically explored, with a view to removing stitch material, and possibly the mesh.

Phone call from Mr D – 18 February 2004
Dr D telephoned Mr A on 18 February 2004 "to learn that he was depressed and was despondent about his situation". Mr A advised Mr D that he felt that he was "most likely stuck with the pain". Mr D advised Mr A to contact another patient who had intractable groin pain following hernia surgery with Mr Breeze, who was also troubled with impotence. Mr D had recently operated on that patient, who had obtained "dramatic relief following surgery".

Operation – Mr D
Dr D operated on Mr A on 15 March 2004. The operation was recorded as "Exploration left inguinal canal/Extensive lysis of adhesions/Removal Mesh and suture material/Repair posterior wall of the inguinal canal". The typed operation note recorded:

"The incision was deepened through the thick, fat layer. There was dense scar tissue following his past surgery. Gradually external oblique was identified and cleared on its outer surface. The inguinal canal was opened and immediately mesh was encountered. This was gradually freed from external oblique and cleared down to the inguinal ligament. Sutures of what appeared to be 2/0 Proline were excised. The main source of problem seemed to be around the superficial inguinal ring/pubic tubercle. The mesh was particularly tightly bound down with scar tissue at this point and there was marked tethering. If there was a nerve entrapment this was the most likely area. The Proline sutures, which were presumably the cause, were excised and the whole area lysed. The ilioinguinal nerve was not seen at any stage during the dissection. Finally when the mesh had been completely removed, which was a difficult process because it was so adherent, and all remaining suture material, a new piece of mesh was inserted to reinforce the posterior wall of the canal. This was again sutured in to place with continuous and interrupted 2/0 Proline but all sutures were left in the form of a small loop so that there was no tight 'snugging' down of any tissues in case there were any small nerve fibres

> that were present that could not be identified. At the completion the mesh was sitting neatly."

Mr D advised me that the finding of mesh within the inguinal canal was to be expected following Mr A's past surgical hernia repair, and the mesh was placed appropriately and satisfactorily repaired the hernia. Mr D further advised that nerve entrapment during hernia surgery can occur despite taking all precautions to avoid it.

Mr A had an outpatient appointment with Mr D on 30 March 2004. Following the consultation Mr D wrote to Mr A's new general practitioner, and stated:

> "It is very nice to report that following the exploration of the left inguinal canal on 15.03.04 [Mr A] describes himself as now being 100%. He has completely lost all the pain that was troubling him pre-operatively. He states [his sexual function is restored] and this is the first time for years and he has done a full day's work without discomfort. He states that prior to surgery he was suicidal and is now very relaxed, happy and optimistic about his future.
>
> On examination he looks very well and cheerful. The wound is healing rapidly. There is still some post operative swelling to settle but this was within normal limits and no untoward features were noted."

Comment on cause of ongoing pain
In the course of Mr A's subsequent care and treatment (described above), it was suggested that Mr A's ongoing pain might have been the result of either an infected mesh or nerve entrapment during surgery.

In commenting on the cause of Mr A's ongoing pain, Mr Breeze advised me that in his opinion Mr A was not suffering from an infected mesh and his pain was not caused by entrapment neuropathy but typical late postoperative pain. Mr Breeze pointed out that blood tests on 14 June 2002 and 6 June 2003 indicated Mr A had an ESR of 1 (normal range 1-15), which would have been higher if Mr A had had an infection in his mesh. Mr Breeze also pointed out that Mr A's pain escalated following surgery (Dr B 's letter of 4 January 2001 described Mr A's pain as intermittent; on 17 July 2001 Mr D described Mr A's pain as constant 3/10 with occasional exacerbations to 7/10; and on 28 November 2003 Mr A's pain is recorded as 7-8/10). Entrapment neuropathy-induced pain usually dates from the time of surgery, and is not consistent with Mr A's late-developing escalating pain. Mr Breeze advised that he took special care intra-operatively to avoid entrapment neuropathy, and observed that Mr D's operation note of 15 March 2004 contains no evidence of entrapment neuropathy.

Mr Breeze noted that the incidence of chronic groin pain is variable following otherwise successful open hernia repair, reported in some literature as occurring in 5% of patients, and in recent literature as in up to 37% following inguinal hernia repair. He also advised that typical late postoperative pain can develop despite the mesh having been positioned and sutured perfectly during the operation.

Independent advice to Commissioner

The following expert advice was obtained from Mr Mischel Neill, general surgeon:

"I have reviewed the following information supplied to me regarding this case and have considered the questions carefully.

[Mr A's] medical records from Norfolk Hospital, marked 'A' pages 1-13

[Mr A's] medical records from the public hospital, marked 'B' pages 14-49

Letter of complaint from [Mr A], received on 11 December 2003, and enclosed documentation, marked 'C' pages 50-67

Records of two phone conversations between this Office and [Mr A], dated 12 February 2004 and 19 February 2004, marked 'D' pages 68-69

Transcript of interview with [Mr A] on 2 March 2004, marked 'E' pages 70-79

Letter to Mr Breeze, dated 18 December 2003, notifying him of the complaint and the matters to be investigated, and Mr Breeze's response to the complaint, dated 9 February 2004, marked 'F' pages 80-89

Request for further information from Mr Breeze dated 27 February 2004, and Mr Breeze's response, dated 11 March 2004, marked 'G' pages 90-91

Request for information from [Mr D], dated 10 February 2004, and [Mr D's] response, dated 19 February 2004, marked 'H' pages 92-100

Request for further information from [Mr A], dated 6 April 2004, and his response, dated 22 April 2004, marked 'I' pages 101-104

Request for information from a general practitioner dated 19 February 2004, and [Mr A's] general practitioner records, marked 'J' pages 105-186

Request for information from [Dr B], [Mr A's] former general practitioner, dated 8 March 2004, and his response, dated 12 March 2004, marked 'K' pages 187-206

Pre-operative period

The appropriateness of Mr Breeze's pre-operative examination of [Mr A]

This man presented with a lump in the groin to his general practitioner, who examined it and diagnosed a left inguinal hernia. [Mr A] was then referred to Mr Breeze for assessment and treatment of this hernia. There is some confusion in the notes as to how long the lump had been present. Mr Breeze examined the lump and diagnosed a small to moderate incarcerated inguinal hernia on the left side. There was clearly no doubt in Mr

Breeze's mind as to the diagnosis, and so no further investigation was necessary. Had there been any doubt then certainly an ultrasound of the area is often helpful. The diagnosis of an inguinal hernia is normally made clinically, and is diagnosed by either the ability to reduce the lump, or feeling a cough impulse on coughing. While there is no mention of this in the notes Mr Breeze is an experienced surgeon, and I would accept the pre-operative examination as being appropriate.

The appropriateness of Mr Breeze's decision to perform a hernia repair on [Mr A]

Once a diagnosis of an incarcerated hernia is made then the appropriate treatment is surgery to remove the incarcerated contents, which is usually either colon or small intestine, and then to repair the hernia. This can either be done by the local open method or by a laparoscopic technique. Mr Breeze's decision to perform a hernia repair was appropriate.

Other matters

The diagnosis appeared to be straight forward and the treatment appropriate.

The operation

Whether the hernia repair operation was performed in accordance with professional standards

[Mr A] underwent an open procedure for repair of the hernia. At operation the incarcerated contents was not present, and presumably had fallen back into the abdominal cavity. A small hernial sac was found, and a standard repair was carried out.

There is nothing recorded in the notes to suggest that the repair was not carried out in accordance with professional standards.

Post-operative care and treatment

Whether Mr Breeze appropriately investigated the cause of [Mr A's] swelling and ongoing pain and discomfort following the operation

The operation went uneventfully. He was covered during the procedure by Gentamicin as an antibiotic prophylaxis. The following day his recovery had been uneventful and he was discharged home. He was then seen on 4 September 2000 by Mr Breeze where he noticed some low grade superficial cellulitis of the medial aspect of the wound, and for this he was started on Flucloxacillin. [Mr A] complained about the lump still being present, but Mr Breeze felt that the lump was too tender to examine at that time.

During this appointment there was no mention by Mr Breeze with regard to bruising or haematoma. Mr Breeze arranged to see him again in October to further investigate the lump if it was still present. An ultrasound was carried out on 27 October 2000, which showed no abnormality in the site of the local tenderness, nor in the inguinal hernia

repair. They did comment on the area below the repair of lobules of fat, which were not compressible, and their comment was that the appearances of the swelling were consistent with the fatty tissue. [Mr A] complained in his report about bruising of his genital area and bruising down to his ankles. No mention of this was made in Mr Breeze's reports nor the GP's notes. Bruising down to the ankles would be severe hemorrhage in which [Mr A] would have been quite anaemic, so there is inconsistency to this point. [Mr A] did not go back to see Mr Breeze again until 1 March 2001, when he complained of impotence. There does not appear to be any mention during this consultation of the tenderness in the inguinal region. He was not seen again by Mr Breeze.

Inguinal hernia repair is always tender for two to three weeks after surgery, and may be swollen and a little bruised. A small percentage in the order of 6-10% of patients will have persistent pain, which is usually attributed to nerve damage or a nerve being caught in the repair. It is reasonable to wait until the inflammation and swelling has settled down following an inguinal hernia repair to see whether the pain settles, and if this does not, then an ultrasound is usually the investigation of choice.

I believe Mr Breeze has appropriately investigated [Mr A's] swelling and ongoing pain.

The appropriateness of Mr Breeze's post-operative management to [Mr A]

The management of post-operative swelling and groin pain in a hernia repair is usually treated expectantly. One needs to wait until the swelling from the operation has settled down, and then investigate if need be via ultrasound, which was carried out. Once it was shown by ultrasound that there was no obvious cause for the pain, then it is usual to wait to see whether this settles down with time. When [Mr A] went back to see Mr Breeze in March 2001, there did not appear to be any mention about the pain or swelling as concern was that of being impotent. There is no anatomical or physiological way in which a hernia repair could initiate impotence. The suggestion in the ultrasound that there may have been a lipoma present, and that there was at least one thrombosed vein in the lower spermatic cord was unlikely to be the cause of his pain. Thrombosed veins in the lower cord are more likely to cause testicular pain, which was not complained of. The lipoma of the cord may well have caused a swelling, but would not cause the pain. At operation in early 2004, [Dr D] did not find a lipoma, or at least no lipoma was mentioned in his operation note. It would appear that the pain was due to entrapment of a nerve in a suture.

I believe that Mr Breeze acted with reasonable care and skill in his treatment of [Mr A], and that he provided services of an appropriate standard."

During a subsequent telephone conversation on 21 June 2004, Mr Neill advised that nerve entrapment is a common risk of surgery. In a further telephone conversation on 6 July 2004, Mr Neill was asked what a reasonable practitioner would have done when [Mr A] re-presented with pain on 1 March 2001. Mr Neill stated that it would have been reasonable either to refer [Mr A] to the pain clinic or to inject the painful area with a

steroid. If those interventions did not help resolve the pain, then the next step would be to explore the wound."

Additional expert advice

In response to my provisional opinion, Mr Breeze further submitted that Mr A's pain was the result of late postoperative pain, and not nerve entrapment. He argued that Mr A's pain developed late, and slowly escalated in accordance with a diagnosis of late postoperative pain. Accordingly, in his opinion Mr A's pain was not present during the consultation on 1 March 2001. Mr Breeze also submitted that hernia pain present over three years postoperatively is "of considerably more concern than pain occurring eleven months postoperatively, particularly when the literature reports an incidence of chronic groin pain postoperatively in up to 37% of hernia operations".

I asked Mr Neill to review Mr Breeze's submissions in response to the provisional opinion and provide additional expert advice. Mr Neill's advice was as follows:

"I have read Mr Breeze's response to your [provisional] opinion and the following are my conclusions to the questions he raised.

It is my belief after discussing the subject of nerve entrapment and late post-operative pain with members of the Pain Clinic at […], as well as three other surgeons who are experienced in hernia repair, that the two conditions are probably indistinguishable, and fall into the overall picture of entrapment neuropathy. Entrapment neuropathy can arise soon after surgery if a nerve is captured in a suture, but it can also occur later on after surgery if the nerve is encased in scar tissue or mesh. Both scar tissue and mesh shrink with time, which can lead to nerve entrapment pain.

The accepted way of diagnosing entrapment neuropathy is to inject the nerve proximal to the scar with local anaesthetic. If the pain is alleviated for the time of the action of the local anaesthetic a diagnosis of entrapment neuropathy is made.

I could find no evidence in the notes of this having been carried out. Bocci in the article Mr Breeze presented claims 7.6% of all cases are affected by severed nerve endings in contact with mesh. He does not say if this is 7.6% of all cases of hernia repair or 7.6% of cases presenting with pain, which would indeed make it very rare. Entrapment neuropathy is reported as occurring in around 6-8% of cases of hernia repair, and is not a reflection on surgical technique. Whereas the condition Bocci describes suggests division of the nerve at the time of surgery. If one was to consider the entity of which Bocci describes as being any different from nerve entrapment, which I believe it is not, the treatment would be the same, that is to explore the wound.

The fact that [Dr D] could not be definite about a nerve entrapment is typical of wound exploration for entrapment neuropathy. The nerve itself is often very difficult to see in the scar tissue, but the pain is frequently relieved by excising the scar tissue or removing the mesh.

The treatment for incarcerated hernia (irreducible) is to open the hernial sac, and remove the contents from the sac and return them to the abdominal cavity. Hence reducing the hernia. Frequently in an incarcerated hernia the contents either omentum (fat) or bowel are held by adhesions to the sac wall, one reason why the hernia is irreducible. These adhesions need to be divided prior to returning the contents to the abdominal cavity. These points, along with the post-operative symptoms, raise the question,

'Was the lump about which [Mr A] complained really a hernia?'

The patient complained of a lump in the left groin.

Mr Breeze diagnosed a tender small to moderate incarcerated left inguinal hernia.

At surgery no incarcerated hernia was found.

No indirect sac was present, but a small direct sac was present. This was inverted with a Prolene suture.

Most incarcerated inguinal hernias are indirect inguinal hernias because the sac may be large, but the opening from the abdominal cavity, internal ring, has a smaller diameter than the sac. Contents are forced into the sac and the constriction of the internal ring cause the incarcerated hernia. It is much less common in a direct hernia, which is a weakness in the posterior wall of the inguinal canal, and so a constriction at the neck of the sac is uncommon.

[Mr A] felt the day after surgery that the lump was still there, but it was too sore to be examined, Mr Breeze recorded.

On the 27th of October [Mr A] was convinced the lump was still present.

An ultrasound carried out did not find a hernia, but found a probable fatty lump.

There is no comment in the notes as to whether Mr Breeze felt this lump was different to the hernia that he had felt.

In answer to your specific questions:

Is it likely that [Mr A's] pain was due to nerve entrapment?

Yes as explained above.

Post-operative pain from hernia repair is very variable, some have very little pain, and require no pain relief, while others suffer from moderate to severe pain, and require varying amounts of pain relief. The pain is due to the wound, to possibly ischaemic tissue from sutures, movement of inflamed tissues, the mesh itself etc.

Most patients are comfortable within seven days, although some may have pain for a little longer. Almost all patients are comfortable enough to resume work within 14-21 days.

Entrapment neuropathy can be early or late onset as mentioned above, and is variable in intensity. Some movements make the pain worse. The pain may persist until treatment is sought. Initially injection of the nerve proximal to the wound with local anaesthetic would lead to the diagnosis, and the area of nerve entrapment is injected with steroid injections. If this does not alleviate the problem surgical exploration of the wound with removal of sutures/mesh/scar tissue and re-repair [of] the hernia is carried out if necessary. As mentioned above late post-operative pain as described by Bocci is probably, at the most, a variant of entrapment neuropathy.

To remove or reduce an incarcerated hernia

As described above the contents of the incarcerated hernial sac are removed from the sac to the abdominal cavity to reduce the hernia.

Does the fact that the ultrasound on 27 October 2000 did not identify any residual haematoma make it unlikely that he was suffering from pain?

No. The haematoma and infection would certainly have been painful, but as this settled, the pain would also settle. Unless there was a large mass of scar tissue or distorted mesh there would be no evidence on ultrasound of nerve entrapment.

Did [Dr B's] letter of 4 January 2001 focus on [Mr A's] impotency and not on his pain?

The letter mentions both impotence and pain. With this history of pain following the surgery and with the associated complications (haematoma, bruising, infection) and the fact that pain was still present four months later should have led Mr Breeze to enquire into this more fully and to try and elicit the cause.

Was it residual pain from the complications?

Was it nerve entrapment?

Was it non-specific pain sometimes seen in hernia repairs?

These questions or points alluding to these should have been recorded in Mr Breeze's notes as residual pain was the result of Mr Breeze's surgery.

I do not understand the statement in Mr Breeze's submission 'That hernia pain present over three years post-operatively is of considerably more concern than pain occurring 11 months post-operatively.' Most surgeons would be just as concerned about pain 11 months post-operatively as 3 years post-operatively."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

Right 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

Right 6

Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

(a) An explanation of his or her condition; and

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option: …

Opinion: No breach – Mr Ian Breeze

The operation
Mr A presented to Mr Breeze with a tender, small to moderate sized, incarcerated left inguinal hernia on 15 August 2000. Mr Breeze recommended a left inguinal hernia repair operation. The operation was performed at Norfolk Hospital on 23 August 2000, using a "Liechtenstein technique". The operation note recorded that mesh was inserted and "split laterally to 'fish-tail' around the emerging cord at the deep ring", and care was taken to avoid entrapment neuropathy. Mr A was transferred back to the ward following the operation, where he made an uncomplicated recovery. Mr A was discharged on 24 August 2000.

Mr Neill advised me that there is nothing recorded in the notes to suggest that the hernia repair was not carried out in accordance with professional standards. I accept Mr Neill's advice. Accordingly, in my opinion Mr Breeze did not breach Right 4(1) of the Code in relation to his surgery on Mr A.

Mr A suffered complications following the surgery, which resulted in further surgery in March 2004. Mr D performed the surgery and noted that the mesh had been particularly tightly bound down with scar tissue, and there was marked tethering. However, he advised me that the mesh was placed appropriately by Mr Breeze and he had satisfactorily repaired the hernia. Mr D advised that it is likely that Mr A's pain was caused by a nerve entrapment, probably in the area of the mesh and possibly in a suture. Mr Neill agreed with Mr D.

Nerve entrapment is a well recognised risk of hernia surgery, and does not necessarily mean that Mr Breeze did not perform surgery with reasonable care and skill. Dr D advised me that nerve entrapment during hernia surgery can occur despite taking all precautions to avoid it, and that was confirmed by my expert advisor. Mr A recovered well from his surgery with Mr D, and his pain resolved.

Mr Breeze does not agree that Mr A's ongoing pain was due to nerve entrapment. Regardless of the exact cause of Mr A's ongoing pain, I accept that the hernia operation was performed in accordance with professional standards.

Opinion: Breach – Mr Ian Breeze

Postoperative care and treatment – August to October 2000
Mr A complained that after his hernia operation he suffered ongoing and at times severe pain and discomfort in his groin area. There is no doubt that Mr A experienced postoperative complications – he developed a wound infection and experienced swelling, bruising and pain in his groin area. However, there is a conflict of evidence in relation to the significance of Mr A's postoperative symptoms.

On the one hand, Mr Breeze advised me that Mr A had some low-grade superficial cellulitis involving the medial aspect of his wound, and associated swelling, but that the swelling and bruising were unexceptional. Mr Breeze recalled that Mr A did not inform him of an adverse response of excessive swelling and bruising. Mr Breeze further noted, "Certainly if any mention of that were made, it was not an aspect of any significance and could only have been made in passing. Otherwise I would have noted this as an adverse post-surgical reaction."

On the other hand, Mr A informed me that following his discharge from hospital on 24 August 2000 his postoperative swelling was extremely severe. He advised me that his legs were swollen and black (the discoloration extending down to his calf at one point), and that he had difficulty walking. He said that he told Mr Breeze this at his outpatient appointment on 4 September 2000, yet Mr Breeze said that his presentation was normal. I note that Mr A also reported the extent of his swelling to his general practitioner, Dr B, in similar terms in December 2000 (which was noted in the medical record).

Because of the conflicting information and lack of detail in Mr Breeze's records, I am unable to determine the exact extent of Mr A's swelling and bruising. However, I accept that it was significant to Mr A and would have been raised with Mr Breeze at the outpatient consultation in September 2000. Mr A's recollection is vivid and remains distressing to him. The question is whether Mr Breeze adequately managed Mr A's swelling and bruising, and pain in his groin.

Mr Neill advised me that the management of postoperative swelling and groin pain in a hernia repair is usually treated expectantly. The site of an inguinal hernia repair is always tender for two to three weeks after surgery, and may be swollen and bruised. It is difficult to investigate the area in the presence of swelling, and it is therefore reasonable to wait until the inflammation and swelling has settled down to see whether the pain also settles. If the pain is still present after the postoperative swelling has settled, it is appropriate to investigate any ongoing pain. Ultrasound is usually the investigation of choice. If ultrasound shows no obvious cause for the pain, it is usual to wait and see whether the pain settles down with time. If the pain does not settle down, it would be reasonable either to refer the patient to the pain clinic or to inject the painful area with a steroid. If those interventions do not help resolve the pain, the next step would be to explore the wound.

At the 4 September consultation (when Mr A's genital area, groin, and upper legs were too swollen and sore to be touched) Mr Breeze told Mr A that his presentation was normal, and arranged to see him in October with a view to arranging an ultrasound if necessary (presumably once the swelling had settled). On the basis of Mr Neill's advice, it was reasonable for Mr Breeze to decide to wait until Mr A's inflammation and swelling had settled before deciding whether further investigation was necessary.

Following Mr A's consultation on 27 October 2000, Mr Breeze referred him for an ultrasound. There are no notes of the consultation on 27 October, but it appears that Mr Breeze made the ultrasound referral primarily because Mr A considered that the lump

remained. On the basis of Mr Neill's advice, it was appropriate for Mr Breeze to refer Mr A for an ultrasound.

No cause of Mr A's pain was identified on ultrasound. Mr Neill noted that once it is shown by ultrasound that there is no obvious cause for the pain, it is usual to wait to see whether the pain settles down with time. In my view, Mr Breeze adequately managed Mr A's symptoms to this point.

Consultation with Mr Breeze – March 2001
Mr A did not consult Mr Breeze again until 1 March 2001, on referral from his general practitioner. In my view, Mr Breeze did not adequately assess and manage Mr A's symptoms or explain the available options at this consultation.

The critical issue for my determination is whether Mr A presented to Mr Breeze on 1 March 2001 with impotence only, or with a wider clinical picture, including ongoing pain. My advisor indicated that if the concern was impotence, as Mr Breeze advised it was, and the earlier symptoms had settled down, it was reasonable for Mr Breeze to refer Mr A to the men's clinic. However, if the pain had not settled down, it would have been reasonable for Mr Breeze either to refer Mr A to the pain clinic or to inject the painful area with a steroid. If those interventions did not help resolve the pain, the next step would be to explore the wound.

Mr A says that at the 1 March 2001 consultation he told Mr Breeze that he continued to suffer severe pain in his groin and gave him a two-page letter describing his experiences since the surgery. He says he mentioned in detail the swelling, discolouration, pain and impotence. Mr A did not keep a copy of this letter.

Mr Breeze advised me that Mr A consulted him on 1 March 2001 for impotence only, and did not mention ongoing pain. He does not recall Mr A giving him a letter at the consultation; if Mr A had done so he would have documented the multiple problems on his computer and notified Mr A's general practitioner. The fact that he had not done so reinforces Mr Breeze's belief that Mr A did not give him a letter. Mr Breeze also said that his routine practice is to retain in his filing cabinet all letters received from patients. He rechecked his filing cabinet and did not find a letter from Mr A.

Mr Breeze submitted that Mr A did not have ongoing pain on 1 March 2001 because:

1. a postoperative haematoma is a self-limiting problem, and would not have caused Mr A's pain over six months after surgery. Mr A's ultrasound scan on 27 October 2000 did not identify a residual haematoma suggesting that he was suffering ongoing pain;

2. the reported presence of intermittent pain in the scar on 29 December 2000 does not confirm that pain was still present on 1 March 2001;

3. when read in its entirety, Dr B 's referral letter, dated 4 January 2001, was for impotence; and

4. Mr A defaulted on follow-up appointments.

Taking account of all the information available to Mr Breeze on 1 March 2001, I am satisfied that Mr A's concern was not limited to impotence, but raised a more complex clinical picture, which a reasonable surgeon ought to have explored further. In particular:

1. Mr A had complained of significant swelling and bruising, and considerable pain, following the hernia operation. Dr B advised me that Mr A's wound haematoma was significant and much greater than he would have expected from hernia surgery. I do not accept Mr Breeze's argument that Mr A would not have been experiencing pain in March 2001 because the scan on 27 October 2000 did not identify a residual haematoma.

2. Mr A consulted Dr B on 14 December 2000, complaining of feeling unwell following his left inguinal hernia repair. Dr B noted that Mr A had a large haematoma. Mr A consulted Dr B again on 29 December 2000, complaining of intermittent pain in his scar, impotence, and genital swelling.

   Mr Breeze argued that the reported presence of intermittent pain in the scar on 29 December does not confirm that the pain was still present on 1 March 2001, and that Dr B 's letter of referral focused on impotence, and conveyed that Mr A's pain was mild. I do not accept Mr Breeze's argument. Dr B's letter of referral to Mr Breeze, dated 4 January 2001, stated: "He [Mr A] is aware of some intermittent pain over the wound site itself, but this certainly is not persistent." Dr B queried whether Mr A's sexual dysfunction might be the result of a surgical complication, for example, venous impairment. By this letter, Mr Breeze was alerted to Mr A's ongoing, albeit intermittent, pain.

3. Mr Breeze noted that Mr A had a record of failing to attend follow-up appointments, which was inconsistent with his complaint that he was suffering from left groin pain in March 2001. The follow-up appointments that Mr A did not attend were:

   - an appointment at the men's clinic made on referral by Mr Breeze after the 1 March 2001 consultation;

   - a follow-up appointment with Mr D after the consultation in July 2001.

   I am not convinced that Mr A's failure to attend these follow-up appointments indicates that he was not suffering pain in his left groin. Mr A said that he did not attend the follow-up at the men's clinic because he was "so disappointed" that Mr Breeze had not dealt with the other problems he was experiencing. His reason for not attending the follow-up appointment with Mr D seems to have been that he became fatalistic about the possibility of any remedy for his pain and decided to put up with it. It seems that it was only after meeting another of Mr D's patients, who had experienced similar problems but had recovered after further surgery, that Mr A decided to see Mr D again. I find Mr A's explanations credible in the circumstances.

4. Four months later, in July 2001, Dr B referred Mr A to Mr D, another general surgeon, for continuing severe left groin pain. Mr D noted: "The ongoing groin pain tends to be constant 3/10 but occasionally he has exacerbations 7/10. Recently whilst shovelling he was doubled over with groin pain … There is no sign of a recurrent left inguinal hernia but there is a tender thickening adjacent to the superficial inguinal ring. The whole area, particularly on the pubic tubercle was extremely tender to palpation."

I am satisfied that Mr A was still experiencing pain on 1 March 2001, and that he would have conveyed his concern about his pain to Mr Breeze during the consultation. It is clear that in Mr A's mind his symptoms were associated with the hernia repair operation by Mr Breeze. I do not believe that he would have consulted Mr Breeze about one symptom without mentioning the other.

In addition, several factors known to Mr Breeze on 1 March 2001 should have prompted him to enquire more fully into Mr A's pain and to try to elicit its cause – in particular, Mr A's history of pain following surgery and associated complications (haematoma, bruising and infection), and the letter of referral from his GP, dated 4 January 2001, which mentioned both pain and impotence.

Even if (as I consider unlikely) Mr A did not inform Mr Breeze of his ongoing pain at the March 2001 consultation, there was sufficient information available to Mr Breeze to alert him to the fact that Mr A was still experiencing pain, and that further investigation was required. Mr Breeze must accept responsibility for his failure to elicit whether Mr A's groin pain had settled in light of his history.

Mr Neill advised me that Mr Breeze should have asked the following questions about Mr A's pain:

1. Was it residual pain from the complications?

2. Was it nerve entrapment?

3. Was it non-specific pain sometimes seen in hernia repairs?

These questions or points alluding to them should have been recorded in Mr Breeze's notes, since the residual pain resulted from surgery he had performed.

Late postoperative pain
Mr Breeze submitted that Mr A suffered from late postoperative pain, not from entrapment neuropathy (as suggested by Dr D and Mr Neill). He stated that late postoperative pain can appear at a variable time after surgery, and is evidenced by late and escalating pain. Mr Breeze suggested that the gradual worsening of Mr A's pain pointed to this diagnosis, and noted that Mr A's pain was described as intermittent in Dr B 's referral letter of 4 January 2001; by 17 July 2001 when Mr D saw Mr A for the first time, Mr D recorded Mr A's pain as a constant 3/10 on a pain scale with exacerbations to 7/10; by 28 November 2003 Mr A

rated the symptoms as 7-8/10 on a pain scale; and Mr D's operation note of 15 March 2004 contained no evidence of entrapment neuropathy.

Mr Breeze argued that the diagnosis of late postoperative pain for Mr A is consistent with Mr A not experiencing (or mentioning) pain at the time of the consultation on 1 March 2001 – that Mr A was not experiencing pain at that time, but his pain increased following the consultation.

In his additional advice, Mr Neill confirmed his opinion that Mr A probably suffered from entrapment neuropathy. In his view, the increase in Mr A's pain over time was not inconsistent with entrapment neuropathy as Mr Breeze argued. Mr Neill advised that, in his opinion, late postoperative pain and entrapment neuropathy:

> "… are probably indistinguishable, and fall into the overall picture of entrapment neuropathy. Entrapment neuropathy can arise soon after surgery if a nerve is captured in a suture, but it can also occur later on after surgery if the nerve is encased in scar tissue or mesh. Both scar tissue and mesh shrink with time, which can lead to nerve entrapment pain. …
>
> Entrapment neuropathy can be early or late onset … and is variable in intensity. Some movements make the pain worse. The pain may persist until treatment is sought. Initially injection of the nerve proximal to the wound with local anaesthetic would lead to the diagnosis, and the area of nerve entrapment is injected with steroid injections. If this does not alleviate the problem surgical exploration of the wound with removal of sutures/mesh/scar tissue and re-repair the hernia is carried out as necessary. As mentioned above late post-operative pain as described by Bocci is probably, at the most, a variant of entrapment neuropathy."

The issue in this case is whether Mr A experienced and described ongoing pain at the 1 March 2001 consultation and, if so, whether Mr Breeze adequately investigated the cause of that pain. Whether the pain was due to entrapment neuropathology or late postoperative pain (and whether there is a difference between the two conditions) is irrelevant to that assessment. As noted by Mr Neill, treatment for both conditions would be the same – surgical exploration of the wound. For the reasons set out above, I am satisfied that Mr A was experiencing and described pain at the time of the March 2001 consultation, and that Mr Breeze did not adequately investigate, or treat, the pain.

Mr Neill also advised that the accepted way of diagnosing entrapment neuropathy is to inject the nerve proximal to the scar with local anaesthetic. If pain is alleviated for the duration of the local anaesthetic, a diagnosis of entrapment neuropathy is made. There is no evidence in his notes that Mr Breeze used an injection of local anaesthetic to assist him in diagnosing the cause of Mr A's pain.

In my view, Mr Breeze's assessment and management of Mr A's condition was inadequate. He did not take a holistic view of Mr A's condition, including his presentation and history. Given the further complaint of pain in March 2001, it would have been reasonable for Mr

Breeze either to refer Mr A to the pain clinic or to inject the painful area with a steroid. If those interventions did not help resolve the pain, the next step would be to explore the wound. In my opinion, Mr Breeze breached Right 4(1) of the Code by failing to take further steps to assess and appropriately manage Mr A's condition during and after the appointment on 1 March 2001.

Mr Breeze's submission that hernia pain three years postoperatively is of considerably more concern than pain occurring 11 months postoperatively suggests a failure to appreciate the pain Mr A experienced. I agree with Mr Neill that reports of pain 11 months postoperatively should be just as concerning to a surgeon as pain three years postoperatively. At any stage, such reports should lead to careful investigation of the possible cause of the pain.

Mr Breeze should also have fully discussed with Mr A all the possible causes of his pain and the management options. Mr A was entitled to that information under Right 6(1)(a) and (b) of the Code. Mr Breeze commented that Mr A's pain was atypical of entrapment neuropathy and that he had taken care to avoid it. Mr Breeze had clearly formed the view that Mr A's condition was not related to surgery. In my view, Mr Breeze should have considered nerve entrapment as a possible cause of Mr A's pain in March 2001. Nerve entrapment was a known risk and a possible cause of his pain, and should have been discussed with Mr A, regardless of the care taken at surgery to avoid it. As noted by my expert advisor, a small percentage of patients (6-10%) have persistent pain following a hernia repair, which is usually attributed to nerve damage or a nerve being caught in the repair. I note that a few months later, Dr D considered that it was a possible explanation for Mr A's condition and managed it accordingly.

Mr A was effectively left 'in the dark' about what the possible causes of his pain could be, what he could expect if his pain did not resolve, and what investigations were available. In this respect, I draw Mr Breeze's attention to the Royal Australasian College of Surgeons' Code of Ethics (September 1993), which states:[2]

> "The surgeon should recognise and preserve the special relationship between surgeon and patient, while acknowledging its inherent inequality, which results from the surgeon's special knowledge and experience. The relationship should at all times be characterised by a trust which allows an honest exchange of information and facilitation of patient autonomy."

Mr A was not adequately informed about his condition. He became depressed and despondent, and felt that he would have to live with the pain.

[2] The Royal Australasian College of Surgeons' Code of Ethics (September 1993) is available at: http://www.racs.edu.au/about/publications/policies_ethics.html.

I note that when Mr A presented to Dr D on 28 November 2003, he developed a treatment plan, including a trial of Voltaren and, depending on the response, infiltration of the tender site around the left pubic tubercle with Kenacort. Dr D also advised Mr A that if there was still no improvement, surgical exploration was an option. This gave Mr A some reassurance that his concerns would be addressed. Mr Breeze did not develop such a plan for the investigation and treatment of Mr A's pain. Had he done so, he may have been able to further investigate Mr A's pain, and limit his suffering. It is likely that this complaint would not have arisen.

This case clearly highlights the importance of keeping patients fully informed about the possible causes of their condition, what to expect from the condition, and what treatment options are available. It is important that patients are informed of, and feel involved in, their management plan. Surgical patients need more than technically competent care – they need effective communication about their treatment.

In summary, Mr Breeze took insufficient steps to assess and manage Mr A's condition in March 2001. He also failed to discuss whether a surgical complication such as nerve entrapment was a possible reason for Mr A's condition, especially in light of Mr A's clear view that his symptoms were a direct result of the surgery. By not further investigating Mr A when he presented on 1 March 2001 with ongoing pain, and by not giving Mr A sufficient information about his condition and involving him in a management plan, Mr Breeze breached Rights 4(1) and 6(1)(a) and (b) of the Code.

Other comment

Conflict of evidence and record-keeping
When complaints about medical care involve conflicting verbal accounts of events, the information in the medical records is very important. If that information is missing, it becomes extremely difficult to establish the facts of a case – as has happened in this case. I am concerned about the inadequate documentation of Mr A's physical presentation, and that Mr Breeze did not keep a written record of his consultation with Mr A on 27 October 2000 or record the details of Mr A's condition leading to the referral for an ultrasound. I draw Mr Breeze's attention to the Medical Council of New Zealand's *Good Medical Practice: A Guide for Doctors* (2000), which states:

> "3. In providing care you must:
>
> … keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."

I also draw Mr Breeze's attention to the Medical Council of New Zealand's *Guidelines for the Maintenance and Retention of Patient Records* (October 2001), which state:

"1. Maintaining patient records

(a) Records must be legible and should contain all information that is relevant to the patient's care.
(b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

Record-keeping is an important part of a doctor's practice. It may assist the doctor by confirming the key details of a consultation and follow-up actions. More importantly, as noted in *Cole's Medical Practice in New Zealand* (2001),[3] keeping a proper medical record is "a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care".[4] The medical record contains vital information relevant to a patient's history, care and treatment, which may be needed if the patient receives subsequent care from other health professionals. The absence of accurate information in those circumstances may impact on later care for the patient. The record must be comprehensive and accurate. I recommend that Mr Breeze review his record-keeping in light of the above statements.

Recommendations

I recommend that Mr Breeze take the following action:

- Apologise in writing to Mr A for his breaches of Right 4(1) and 6(1) of the Code. Mr Breeze's apology should be sent to my Office, and will be forwarded to Mr A.

- Review his practice in light of my report.

Follow-up actions

- A copy of my report will be sent to the Medical Council of New Zealand and the Royal Australasian College of Surgeons.

- In light of the significant public interest in my inquiry into Mr Breeze's practice, a copy of my report, with details removed identifying all parties other than Mr Breeze, my

[3] Edited by Dr Ian St George and published by the Medical Council of New Zealand.
[4] *Cole's Medical Practice in New Zealand* (2001), ch 10, p.80.

expert advisor, and the hospitals, and with the highly personal details of Mr A's condition paraphrased (in light of the risk that he may nonetheless be identified), will be released to the media and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

In response to my final report, Mr Breeze made the following submission:

"Your final report contains factual errors which surely must be corrected.

Your expert advisor misquotes the incidence of typical late postoperative pain.

Bocci reports this in 7.6% of 1000 patients, not 0.76% as quoted by Mr Neill. Mr Neill reports that he is uncertain as to whether Bocci is referring to the percentage of patients undergoing hernia repair, or the percentage who develop pain after hernia repair. As Bocci has not stated his total incidence of pain post hernia repair, the percentage clearly refers to the number of patients undergoing hernia repair, or the figure would be meaningless. However, either way, the incidence of typical late postoperative pain is significantly higher than Mr Neill suggests.

Secondly, both Mr Neill and you opine that the presence of hernia pain occurring eleven months postoperatively is just as serious as that occurring three years postoperatively. I did not see [Mr A] eleven months postoperatively. The last time I saw [Mr A] was 1 March 2001, less than seven months postoperatively. Whereas chronic groin pain is reported to occur in up to 37% of patients post hernia repair, only a very small proportion of these undergo re-operation (less than 0.2% of my patients). I am concerned that your opinion is based on hindsight. Surely the issue is not simply the absence or presence of pain, but the severity of the pain. Clearly [Mr D], an experienced hernia surgeon, does not agree with you, as when he saw [Mr A] eleven months postoperatively he recommended Voltaren and rest, whereas at three years postoperatively he recommended reoperation.

I also wish to address the appropriateness of your selection of Mr Neill in his role as expert advisor on [Mr A]. Mr [Neill] is a colorectal surgeon and I am unaware of how much hernia surgery he undertakes currently. He has not provided any evidential basis for his opinions. Specifically, he advocates injection of local anaesthetic and steroid into the painful hernia wound. To support this, what evidence does Mr Neill have of the utility of this?

…

Names (other than Mr Breeze, the Commissioner's expert advisor and the hospitals) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I would be grateful if you would correct the errors in your final opinion and re-open the case and give careful consideration to my comments, and reverse your opinion that I have breached the Code. It is not sustainable given the errors I have highlighted. I await your reply."

Mr Neill responded to Mr Breeze's submission as follows:

"1. With respect to the paper by Bocci I would agree with Mr Breeze there is a typing error. The report should read 7.6% of 1000 patients. The report does not make it clear as to whether these were 1000 patients with pain or a 1000 patients that he operated on. If you take this as 7.6% of patients having inguinal hernia repair this figure is sitting at the level that the literature describes for nerve entrapment syndrome of 6-8%. It is relatively recently that mesh has been used for repair of hernias. This major change came about when Liechtenstein wrote his paper using mesh, and certainly if Bocci's report is to be considered it then puts the entrapment nerve pain at a much higher level than these figures.

2. The comment made about hernia pain 11 months post-operatively being as serious as that occurring three years post-operatively is a comment made about the reference in Mr Breeze's previous report. These were the figures he used. I agree with his comment that only a few patients go through to re-operation, as a number are helped by injection of local anaesthetic and steroid as mentioned in the previous report. Methods such as Voltaren and rest also play a part. However, if these do not work then these people usually end up having the wound explored.

3. While doing general surgery as well as colorectal surgery my experience with hernia repair would have been similar to most surgeons in Auckland. I still repair hernias, but certainly not the numbers I used to. With respect to his last comment in this paragraph I did not advocate injection of local anaesthetic and steroid into the painful hernia wound. The injection is injected around the nerve proximate to the wound, and if this alleviates the pain, then an injection of steroid is placed into the point of pain, once the local anaesthetic is working. This is standard practice in the Auckland Pain Clinic, which deals with cases such as this from large areas of New Zealand. …"

Factual inaccuracy
I have corrected the one factual inaccuracy in Mr Neill's advice (included in my report), regarding Bocci's reference to the percentage of patients undergoing hernia repair.

Request to reopen
Mr Breeze requested that I reopen my investigation. The Commissioner's power to reopen a file is a discretionary power, to be exercised only in exceptional cases where justice demands that an investigation be reopened. It must be exercised fairly, in accordance with principles of administrative law.

Mr Breeze identified an error of fact in Mr Neill's advice (included in my report). I have corrected the error and amended my report. The error is not significant to my overall findings in this case, and is not a reason to reopen my investigation.

Names (other than Mr Breeze, the Commissioner's expert advisor and the hospitals) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.