Obstetrician and Gynaecologist, Dr B

A Report by the

Health and Disability Commissioner

(Case 04HDC03651)

Parties involved

Mrs A	Consumer
Dr B	Obstetrician and gynaecologist/Provider
Dr C	Obstetrician and gynaecologist
Dr D	Obstetrician and gynaecologist
Dr E	General practitioner
Dr F	Obstetrician and gynaecologist

Complaint

On 5 March 2004 I received a complaint from Mrs A about the care provided to her by Dr B, obstetrician and gynaecologist. The issues identified for investigation were:

- *Whether Dr B appropriately assessed and treated Mrs A's condition.*
- *Whether Dr B adequately informed Mrs A about her condition and the options for treatment.*

An investigation was commenced on 17 March 2004.

Information reviewed

Information from:
- Mrs A
- Dr B
- Dr C
- Dr D
- Dr E.

Independent expert advice was obtained from Dr Guy Gudex, obstetrician and gynaecologist.

Names 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

Background
The complaint made by Mrs A against Dr B concerns the diagnosis and treatment of endometriosis.

Endometriosis is a common gynaecological condition, particularly among women of child-bearing age; it may cause debilitating chronic pain, although some women have no symptoms at all. Endometriosis may also cause infertility.

The name comes from the word "endometrium", which is the tissue that lines the uterus. During a woman's regular menstrual cycle, this tissue builds up and is shed if she does not become pregnant. Women with endometriosis develop endometrial tissue outside the uterus, usually on other reproductive organs inside the pelvis or in the abdominal cavity. Each month, this misplaced tissue responds to the hormonal changes of the menstrual cycle by building up and breaking down just as the endometrium does, resulting in internal bleeding.

Unlike menstrual fluid from the uterus, which is shed by the body, blood from the misplaced tissue has nowhere to go, resulting in the tissues surrounding the endometriosis becoming inflamed or swollen. This process can produce scar tissue around the area, which may develop into lesions or growths.

The American Society of Reproductive Medicine (ASRM) has developed a classification or staging system for endometriosis. The stage of endometriosis is based on the location, amount, depth, and size of the endometrial lesions, which are given a score depending on extent and severity. The stage of the endometriosis does not necessarily reflect the level of pain experienced, risk of infertility, or symptoms present. For example, it is possible for a woman in Stage I to be in tremendous pain, while a woman in Stage IV may have no symptoms.

The stages of endometriosis are:

Stage I:	Minimal	total score of 1–5
Stage II:	Mild	total score of 6–15
Stage III:	Moderate	total score of 16–40
Stage IV:	Severe	total score of >40

Chronology of events
In September 2001, Mrs A was referred by her general practitioner, Dr E, to Dr B, as a private patient, as Mrs A had been experiencing difficulty in becoming pregnant. In reference to Mrs A's initial consultation on 5 September 2001, Dr B stated:

> "I took a detailed history … . At that time [Mrs A] reported dysmenorrhoea (pain associated with periods) on the 1st day of her period. Her menstrual cycles were

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regular, periods lasting for three days. Of particular note, she had no symptoms of dyspareunia (painful intercourse) congestive type of dysmenorrhoea, tiredness, or tenesmus as is often present with severe endometriosis."

Dr B arranged a hysterosalpingogram[1] (HSG), which was performed on 25 September at a public hospital and reported by a radiologist, as follows:

"An HSG was performed without complication. There was normal filling of the right tube. There was slightly sluggish peritoneal spill demonstrated on this side. The left tube is abnormal. No normal tube thickening could be identified. Several centimetres from the cornu there is a thickened tubular structure which has partially filled with contrast. This appearance suggests a hydrosalpinx."[2]

On the basis of the HSG results, Dr B performed a laparoscopy on 17 December 2001 at a private hospital in a town. The operation record states that Dr B was assisted during the procedure by Dr F.

Dr B stated:

"On laparoscopy, the whole pelvis was found to be extremely congested. There were some fine adhesions between the left tube and ovary as well as near the corneal end of the right tube. There was some unusual bleeding from the posterior surface of the uterus and the base of the left uterosacral ligament. There were no obvious spots of endometriosis. There were no obvious nodules or other specific features of endometriosis, such as flame-like lesions, etc. Because the findings were not definitive, I sought an opinion from [Dr F] … who happened to be present in the hospital. Two possibilities were considered. 1) Endometriosis and/or 2) Pelvic Inflammatory Disease."

Dr B wrote to Dr E on 17 December informing her that she was treating Mrs A for possible pelvic inflammatory disease.

On 20 December, Mrs A attended a postoperative consultation with Dr B, who recollected explaining that the laparoscopy indicated the possibility of pelvic inflammatory disease or endometriosis, and discussing both medical and surgical treatment options for endometriosis. Dr B did not consider surgery appropriate at the time and, in view of the non-specific findings, she recommended medical treatment with Danazol,[3] and discussed a

[1] Hysterosalpingogram: radiological investigation of the uterus and fallopian tubes.
[2] Hydrosalpinx: accumulation of water in the fallopian tube, causing swelling.
[3] Danazol: (*New Ethicals Compendium*, 7th ed.): "[Danazol] therapy has been successful in the treatment of endometriosis, relief of the common presenting symptoms of dysmenorrhoea, pelvic pain and dyspareunia … Significant reversal of infertility associated with endometriosis has followed a course of [Danazol] therapy."

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repeat laparoscopy in six months' time. She gave Mrs A an information pamphlet on Danazol therapy.

Dr B's clinical record of 20 December 2001 states:

> "Explained finding
> Most likely endometriosis.
> Danazol for [six months] then laparoscope again and try for pregnancy then. … IVF if not pregnant in [six months] after [stopping] Danazol. …
> Stop Augmentin."

There is no reference to the ASRM Guidelines in Dr B's clinical record, and Dr B did not record any classification of Mrs A's endometriosis using the ASRM Stage I to IV classification. Dr B stated:

> "I do not routinely use the staging document of the American Society for Reproductive Medicine."

However, Dr B told Mrs A at a subsequent meeting (in August 2003) that she does use the ASRM guidelines to assess the severity of endometriosis.

Dr B wrote to Dr E on 20 December 2001 with the results of Mrs A's laparoscopy:

> "… I saw [Mrs A] and discussed the laparoscopic findings with her which could either be from pelvic inflammatory disease with the appearance of very early endometriosis.
>
> In view of this I am treating her with Danazol and I have explained the side effects of it. We will be treating her initially for six months and then stopping and seeing if she can conceive."

When Mrs A was informed that she had pelvic inflammatory disease she was not convinced of the diagnosis, and told Dr B this. In response to my provisional opinion, Mrs A stated:

> "I got the impression that I was a nuisance and it wasn't worth her time and effort to deal with my concerns about my general health and in particular my fertility. I was never once told how I could have contracted Pelvic Inflammatory Disease or even what it actually was and what symptoms I could have been experiencing. … I had already been trying to conceive for 11 months, how long did [Dr B] think that I was emotionally going to be able to withstand drugs preventing me from getting pregnant?"

Mrs A suffered some side effects from Danazol, and on 8 February 2002 Dr B prescribed Provera as an alternative treatment. Mrs A also suffered some side effects from Provera

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and, following a further consultation on 16 April 2002, Dr B applied to Pharmac for special authority to prescribe GnRH[4] analogue.

Mrs A consulted Dr E on 1 May 2002. Dr E recorded in Mrs A's notes:

> "Not entirely happy with care from [Mrs B] and asking for [referral] elsewhere — refer [Dr D] [privately]."

Mrs A consulted Dr D, obstetrician and gynaecologist, on 20 May 2002 prior to going overseas, where she was to stay until September 2002. Dr D stopped the prescription of Provera.

Following her return from overseas, Mrs A underwent a cycle of fertility treatment, which was unsuccessful.

In November 2002, Mrs A asked Dr D to stage her endometriosis, based on the photograph taken during the laparoscopic procedure on 17 December 2001. Dr D wrote on 7 November 2002 to Mr and Mrs A and stated:

> "I have graded your endometriosis as Stage III or moderate on the basis of the photograph."

Mrs A informed me that in view of the fact that Dr B had diagnosed her with early endometriosis, she "got a real shock when Dr D phoned me to tell me I had Stage III endometriosis. … I then made my decision to investigate my endometriosis further before I continued with any other fertility treatment."

Mrs A referred herself to Dr C, obstetrician and gynaecologist, and showed him the photograph taken by Dr B. In his letter of 1 December 2002 to Dr E, Dr C wrote:

> "From the photograph that [Mrs A] supplied she has at least got Stage three endometriosis."

On 31 January 2003, Dr C performed a laparoscopic excision of Mrs A's endometriosis, together with an appendicectomy and ventrosuspension. He determined that Mrs A's endometriosis had advanced to Stage IV. He stated in his operation note (copied to Dr E):

> "Both Fallopian tubes and each ovary were adherent to the back of the uterus and the rectum was adherent to the right adnexa. There was obliteration of the Pouch of Douglas and pararectal gutters in the deep pelvis. The appendix was adherent over the pelvic brim to the infundibular ligament on the right side and the distal third

[4] GnRH: gonadotropin releasing hormone.

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> seemed somewhat thickened and possibly affected by endometriosis. The cause for adhesions was severe endometriosis."

In light of Dr C's comments, Mrs A stated:

> "It may have been a 13 month time frame from [Dr B's] initial laparoscopy to my first operation with [Dr C], but has anybody taken on board the fact that for at least 5 months of this time I was on drugs, to prevent me having a period, ovulation and this was meant to help with calming the endometriosis down, not to make it develop rapidly. … can it really progress that rapidly in that time?"

Dr C performed a second operation on 16 April 2003, recording it in his notes as a "laparoscopic excision of ? Stage III endometriosis and re-positioning of ovaries".

Mrs A consulted Dr C on 9 August 2003. His letter to Dr E following the consultation stated:

> "[Mrs A] came to see me delighted that her quality of life has improved dramatically since undergoing laparoscopic excision of endometriosis and also that day-21 Progesterone assays show that she is spontaneously ovulating. … I have discharged [Mrs A] from my care at this point but would be happy to see her again in the future should the need arise. I have advised [Mrs A] that if she has not conceived by the end of the year that she should proceed with [Dr D] to once more consider IVF."

Subsequent events
Mrs A and Dr B met on 12 August 2003 in an attempt to resolve Mrs A's concerns about the care provided to her.

At the meeting Dr B used a copy of the ASMR guidelines to explain to Mrs A the various stages of endometriosis. Mrs A stated:

> "[Dr B] told me that she used the ASMR guidelines to assess the severity of endometriosis patients. In fact she gave me a copy of the guidelines."

Mrs A was unsatisfied with Dr B's response to her concerns, and on 3 March 2004 made a formal complaint to my Office.

On 17 November 2003, Mrs A called Dr C's clinic to advise that she was pregnant, and on 2 August 2004 Mrs A informed my Office that she had given birth.

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Independent advice to Commissioner

The following expert advice was obtained from Dr Guy Gudex, obstetrician and gynaecologist:

"RE: [Mrs A] Ref 04/03651

Thank you for your request to provide independent expert advice about whether [Dr B] provided an appropriate standard of care to [Mrs A].

I have read and agreed to follow the guidelines for independent advisors as outlined in the enquiries and complaints manual from the Office of the Health and Disability Commissioner.

My relevant qualifications are FRANZCOG, FRCOG, Certificate in Reproductive, Endocrinology and Infertility (CREI).

My current position is Clinical Director of Fertility Plus, National Women's Health, Auckland City Hospital.

My training and experience relevant to endometriosis includes current credentialing with Auckland City Hospital for the surgical treatment of advanced endometriosis, I have worked in the endometriosis service at National Women's Health for the last seven years and have convened for the last nine years, the annual National Women's Hospital laparoscopic surgery conference, and participated in associated surgical workshops with those, that in most years have included endometriosis.

The instructions that I received from the Commissioner were *to provide independent expert advice as to whether [Dr B] provided an appropriate standard of care to [Mrs A].*

I have read through the letter of complaint by [Mrs A] dated the 3rd March 2004, and I have also read through the letters and operation notes of [Dr B], [Dr D], and [Dr C]. I have also had the opportunity to look at the clinical photograph taken intra-operatively during the original laparoscopy dated the 17th December 2001.

Background:

[Mrs A] had an initial consultation with [Dr B] on the 5th September 2001.

At that time it was recorded that [Mrs A] was 31 and she had been trying to conceive for 11 months, having stopped the pill five years earlier. She has used natural family planning since then.

Her periods were noted to be regular with dysmenorrhoea present, for which she usually used Ponstan.

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Dyspareunia was noted as being absent.

Vaginal examination performed by [Dr B] at that first consultation showed the uterus to be retroverted but mobile, and tenderness in the right adnexa, but no adnexal masses palpable.

The initial plan of management was to request a hysterosalpingogram and it had been noted by [Dr B] that the luteal phase progesterones done in July and August had confirmed ovulation.

At the second consultation on the 7th November 2001, the hysterosalpingogram findings were discussed, and a diagnostic laparoscopy and dye was planned, with a discussion about the procedure and the risks involved documented.

The hysterosalpingogram had been performed on the 25th September 2001 at the radiology department at [the public hospital], and this was reported as showing normal filling of the right tube, with peritoneal spill confirmed, but that the left tube was abnormal with no tubal filling identified and several centimetres from the cornua, there was a thickened tubular structure which partially filled with contrast, the appearances reported as suggesting a hydrosalpinx.

The diagnostic laparoscopy was performed on the 17th September 2001 and the procedure was described as uncomplicated.

In the letter dated the 17th September 2001 addressed to [Dr E] the general practitioner, [Dr B] described the findings at laparoscopy *'the uterus and both tubes and ovaries, especially the left side appeared to be very inflamed, and there was bleeding from the outer surface of the tube'*. This appeared to be because of pelvic inflammatory disease. Although both of the fimbrial ends of the tubes were free, dye could only be seen coming out of the right tube. The appendix appeared healthy as did the under surface of the liver and diaphragm.

At the time of the laparoscopy the uterus was noted to be retroverted.

The comment was then made that [Dr B] thought that this represented pelvic inflammatory disease and that treatment with Augmentin had been administered (see letter 17.12.01 to [Dr E]).

In a further letter dated the 20th December 2001, [Dr B] again described to [Dr E] the discussion she had with [Mrs A] regarding the laparoscopic findings and explained that this could be pelvic inflammatory disease with the appearance of very early endometriosis.

In view of this, the plan was to treat [Mrs A] with Danazol for six months with the plan of then stopping it and seeing if she would then conceive.

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[Mrs A] did not tolerate Danazol particularly well, and changed to Provera and had been referred in May 2002 by her General Practitioner to [Dr D] for further assessment.

[Dr D] commented that [Mrs A's] principal concern was fertility rather than dysmenorrhoea and IVF was recommended.

While waiting for IVF, Clomiphene intrauterine insemination was tried and a decision was then made for referral to [Dr C] for consideration of laparoscopic excision of endometriosis.

This was performed in January 2003.

The operation note described the uterus as being anteverted and of normal size. Both fallopian tubes and each ovary were adherent to the back of the uterus and the rectum was adherent to the right adnexa.

There was obliteration of the Pouch of Douglas.

The appendix was adherent over the pelvic brim to the infundibular ligament on the right.

The endometriosis was assessed as being Stage IV, extensive excision was performed, and a further laparoscopic procedure was then carried out by [Dr C] a couple of months later.

I note that subsequently [Mrs A] has conceived.

Expert advice:

1) Is endometriosis evident in the photograph taken on the 17th December 2001 during the procedure performed by [Dr B]?

On inspecting the digital photograph taken on the 17th December 2001, there are superficial changes in the left ovary and the peritoneum in the cul-de-sac and the uterosacral ligaments consistent with endometriosis.

The stage of the endometriosis cannot accurately be assessed from a single photograph, but there are certainly changes superficially on the left ovary consistent with endometriosis (flame like lesions), and it is noted that the tubes otherwise appear normal, although the left fimbrial end is not visible.

The bulk of the peritoneum and the ovarian fossae are not visible in the photograph as they are obscured by the ovaries, but certainly the peritoneum and the cul-de-sac appeared thickened and haemorrhagic, as do both uterosacral ligaments and the posterior surface of the uterus.

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[Dr B] noted bleeding from the back of the uterus at the time of the laparoscopy with the findings of a retroverted uterus, one possible explanation for this finding was that the anteversion of the uterus achieved with uterine manipulation may have broken down some adhesions on the back of the uterus provoking the bleeding.

Based on these findings, I would stage the endometriosis visible in the photograph, as a minimum of Stage II, using the revised American Fertility Society classification system (eleven points).

2) Was the treatment regime recommended by [Dr B] following the laparoscopy on December 17th appropriate?

[Dr B] discussed the possibility of the findings being attributable to endometriosis at the post operative consultation.

The options would include expectant management (ie wait and see if conception occurred spontaneously), surgical treatment of the endometriosis (ie further laparoscopic excision) or referral to a Fertility Specialist to discuss assisted reproductive options in light of the finding of a unilateral tubal block.

There is no evidence to suggest that medical therapy such as Danazol will increase the chances of subsequent conception, and in my opinion should only be considered if symptoms such as pain need controlling and fertility is not desired.

I am not aware of any RANZCOG[5] guideline advising against the use of medical therapy however.

It is not clear from the peri-operative notes or operation notes as to whether cervical and vaginal swabs were taken.

The post operative letter to [Dr E] dated 20th December 2001 stated 'I saw [Mrs A] and discussed the laparoscopic findings with her, which could either be from pelvic inflammatory disease with the appearance of early endometriosis. In view of this, I am treating her with Danazol and I have explained the side affects of it. We will be treating her initially for six months and then stopping and seeing if she can conceive.'

I note that [Dr B's] hand written note from the consultation dated the 20th December 2001 stated 'most likely endometriosis. Danazol for six months, then laparoscope again and try for pregnancy then. IVF if not pregnant in six months after finishing Danazol.'

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[5] Royal Australian and New Zealand College of Obstetrics and Gynaecology.

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It seems clear therefore that [Dr B] did consider the various options for managing this case, but these may not have been clearly communicated or understood by [Mrs A].

Overall, I believe the regime recommended (medical therapy) was not the most appropriate, but most of her peers would view this with mild disapproval only.

3) Is the description of the laparoscopy findings as non-specific accurate?

Although there were no blue/black lesions visible in the peritoneum as is sometimes seen in endometriosis, it has been well recognised for many years that endometriosis can present as haemorrhagic peritoneum.

The fact that there were no significant peritubular or periovarian adhesions noted and seemingly normal fimbriae would make a diagnosis of pelvic infection unlikely in my opinion.

Although the preoperative hysterosalpingogram had raised the possibility of a hydrosalpinx on the left, the appearances at laparoscopy in my opinion were not suggestive of pelvic inflammatory disease, given the normal fimbrial ends that were seen and the lack of peritubular and periovarian adhesions.

4) Please describe the staging process for endometriosis.

The generally accepted staging process for endometriosis is the American Society for Reproductive Medicine (ASRM) revised classification for endometriosis (1996).

This classification stages endometriosis in to I (minimal to 5 points), II (mild 6 to 15 points), III (moderate 16 to 40 points), and IV (severe greater than 40 points).

The classification is based on assessing peritoneal surfaces, ovarian adhesions, tubal adhesions, ovarian endometriosis and involvement of the posterior cul-de-sac.

5) Is it possible for endometriosis to develop from Stage I to Stage IV within thirteen months? Please comment on the usual progress of endometriosis from Stage I to Stage IV.

It is possible for endometriosis to develop rapidly over an approximate 12 months time frame, but this would be unusual and it is more often that the original severity of the endometriosis is under estimated.

Nevertheless, it is clear from [Dr C's] operation note, of his first laparoscopic procedure, that there had been significant progression in the staging of the endometriosis with his findings of both fallopian tubes and ovaries being adherent to the back of the uterus and the rectum being adherent to the right adnexa.

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The appendix was also adherent to the infundibular ligament on the right side, and it is clear from the original operation findings of [Dr B], that in fact the tubes and ovaries were relatively mobile, and there is no advanced Pouch of Douglas obliteration.

6) How much variability is present in the measurement of the clinician of the stage of endometriosis?

Many clinicians continue to not formally stage endometriosis at the time of surgery using the ASRM classification system.

Several studies have confirmed variability present, and intra observer variation, and it has also been well recognised that the current classification system does not predict severity of symptoms or prognosis in terms of fertility particularly well.

I note that in the post operative consultation of the 20th December 2001, [Dr B] has noted that she explained the findings to [Mrs A], and she has noted that the most likely diagnosis was endometriosis.

[Dr B] comments that at the time of the laparoscopy, she requested a second opinion from [Dr F], who it was stated regularly performed laparoscopic treatment of endometriosis.

No biopsy was considered at the time of the initial laparoscopy.

Opinion:

In my opinion the overall care that [Mrs A] received from [Dr B] was of an appropriate standard.

I believe that most of her peers would view her advice regarding the benefit of medical therapy (Danazol) for a patient with infertility with mild disapproval.

Given [Mrs A's] desire for fertility, the appropriate management plan following the laparoscopy was either to refer on for definitive surgical treatment of the endometriosis or to advise [Mrs A] to continue to attempt to conceive spontaneously notwithstanding the concern about the patency of the left tube, and that referral for assisted reproduction, such as IVF, may be necessary if conception did not occur in the following six to twelve months.

The preoperative care and assessment provided by [Dr B] was appropriate, and the hysterosalpingogram findings may have influenced her assessment of the laparoscopic findings, particularly with the possibility of a hydrosalpinx having been raised as a result of the radiology report.

[Dr B] is to be commended for her willingness to obtain a second opinion intra-operatively, when the findings seemed confusing, although I note that consideration

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was not given to performing a peritoneal biopsy which may have made the diagnosis clear."

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.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.*

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 — Dr B

Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that patients have the right to have services provided with reasonable care and skill, and that comply with legal, professional, ethical, and other relevant standards. Mrs A alleges that Dr B failed to diagnose and appropriately treat the endometriosis from which she suffered.

Diagnosis and assessment of endometriosis
Assessing the clinical picture as a whole, and on the basis of radiological investigations and laparoscopy, Dr B considered that Mrs A was suffering from very early endometriosis and

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commenced treatment. In reaching her diagnosis, Dr B obtained a second opinion from her colleague, Dr F, who assisted in the procedure.

Endometriosis was Dr B's preferred diagnosis, and is written in the notes of her consultation with Mrs A on 20 December 2001, recording "explained finding … most likely endometriosis". The probable diagnosis of very early endometriosis was also communicated by Dr B to Dr E in a letter of the same date. Mrs A recalls being told she had very early endometriosis and pelvic inflammatory disease.

Although Dr B correctly diagnosed Mrs A's endometriosis, there remains the issue whether in December 2001 she correctly assessed or "staged" its severity. Was Mrs A suffering from very early endometriosis, as Dr B considered, or was it more advanced, as subsequently advised to Mrs A by Drs C and D?

In November and December 2002, Drs D and C each assessed the severity of Mrs A's endometriosis from the single photograph taken in December 2001 during the laparoscopy. They considered that the endometriosis could be measured at Stage III, or moderate. It is not entirely clear whether Dr B routinely uses the ASRM classification system, but it appears from her description of Mrs A's endometriosis that she did not use it in this case. It is therefore difficult to compare the views of Drs C and D with the assessment made by Dr B.

Dr Gudex advised that "the stage of endometriosis cannot accurately be assessed from a single photograph". This is significant when one also considers that during the procedure on 17 December 2001, Dr B had the benefit of a more extensive assessment via the laparoscope than a single photograph, and she also obtained a second opinion from Dr F.

Dr Gudex also advised that there are "changes superficially on the left ovary consistent with endometriosis", which he described as "flame-like lesions", although he stated that the fallopian tubes appeared normal. Dr B stated that there were no "obvious spots of endometriosis … or other specific features of endometriosis, such as flame-like lesions".

Dr Gudex advised that it is possible for a progression from "early" to Stage IV to occur in 13 months, but that it would be more likely that the original severity of the endometriosis had been underestimated.

In light of Dr Gudex's view that the photograph shows a minimum of mild[6] endometriosis, and Dr B's opinion that it was very early endometriosis, I am not convinced that there is any material difference between the differing views. Overall, I am satisfied that Dr B correctly diagnosed and assessed Mrs A's endometriosis in December 2001, even if she did not use the ASRM classification and did not notice the flame-like lesions.

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[6] Dr Gudex gave a score of 11 in reaching the opinion that the photograph of 20 December 2001 showed Stage II endometriosis. The score range for Stage II is 6–15.

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Treatment of endometriosis
Dr B prescribed Danazol to Mrs A following the postoperative consultation on 20 December 2001. Dr B discussed the proposed therapy with Mrs A and gave her a pamphlet about the medication. Mrs A expressed concern that she had consulted Dr B with fertility as her primary concern, and that Danazol was not appropriate.

While the RANZCOG guidelines do not advise against the use of Danazol as medical management for endometriosis, Dr Gudex advised that if fertility is important to the patient, the more appropriate treatment is as follows:

> "[E]xpectant management (ie wait and see if conception occurred spontaneously), surgical treatment of the endometriosis (ie further laparoscopic excision) or referral to a Fertility Specialist to discuss assisted reproductive options in light of the finding of a unilateral tubal block.
>
> There is no evidence to suggest that medical therapy such as Danazol will increase the chance of subsequent conception, and in my opinion should only be considered if symptoms such as pain need controlling and fertility is not desired."

However, Dr Gudex stated that most of Dr B's peers would view management of Mrs A using Danazol with mild disapproval only.

Discussion of treatment options
Mrs A alleges that Dr B told her that surgery was not an option for her endometriosis and would not rectify the blockage within her fallopian tube.

Dr B stated that the full range of treatment options for endometriosis, including surgical management, was discussed with Mrs A. Dr B's plan to continue with medical treatment for six months prior to having a second laparoscopy is recorded in the clinical notes. She considered that surgery in December 2001 would have been inappropriate based on the laparoscopic findings of very early endometriosis.

Dr Gudex advised:

> "It seems clear … that [Dr B] did consider the various options for managing this case, but these may not have been clearly communicated or understood by [Mrs A]."

It appears that Mrs A was left unclear about the nature of her condition, and the pros and cons of various treatment options. Although the evidence is not firm enough to support a breach finding against Dr B, I take this opportunity to remind her of the importance of fully explaining a patient's condition and discussing the available treatment options in a clear and comprehensive manner.

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Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and RANZCOG.
- A copy of this report, with details identifying the parties removed, will be sent to Women's Health Action Trust, and the Federation of Women's Health Councils Aotearoa.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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