

**Prescription of diclofenac to a patient who had previously  
experienced an adverse reaction  
(13HDC01041, 25 May 2015)**

*General practitioner ~ Medical centre ~ Diclofenac ~ Adverse reaction ~ Medical history ~ Risks ~ Monitoring ~ Rights 4(1), 6(1)(b), 7(1)*

A man who had a complicated medical history and was taking several medications went to a medical centre with shoulder pain and was prescribed diclofenac (trade name Voltaren).

Several months later he was reviewed following an episode of faintness. Blood test results showed a significant deterioration in renal function and the GP at the time thought the diclofenac, prescribed previously, might be causing the deterioration and he documented this in the man's clinical notes. That GP told the man to stop taking the medication and advised him not to take it again. A warning was placed on the clinical file stating "Diclofenac sodium – renal failure/retention – avoid".

The man later saw another GP for a check up. This GP recorded at the time in the man's clinical notes "Note renal impairment with addition of Diclofenac".

Five years later, the man saw the second GP again for ongoing ankle pain not relieved by ibuprofen. The GP prescribed a two week supply of diclofenac and advised the man to return in one month for a blood test to check his renal function. The GP said that he did not recall that the man had previously had a bad reaction to diclofenac and did not remember any warning coming up on the computer system about a previous reaction. Due to the merging of the medical centre with another practice at the time and "possible computer difficulties" in the lead up to, and during the merger, the warning may not have featured at the time.

The man returned the following month with pain in the joints of his right foot. The GP made a diagnosis of probable gout and recommended that he keep taking the diclofenac. Two days later the man returned to the GP complaining of being unable to pass urine. The GP diagnosed urinary retention and referred him to the public hospital.

The man was assessed at the public hospital that day and was diagnosed with acute on chronic renal failure. It became evident that the man had had issues with 'Voltaren' and renal impairment in the past and that he had not realised that diclofenac and Voltaren were the same thing. The man began showing signs of multi-organ failure and sadly passed away.

By failing to appropriately establish the man's medical history either by adequately questioning him or reviewing his clinical notes, by failing to take adequate regard of the man's NSAID associated risks, particularly cardiovascular risks and interaction with concurrent medication and by failing to adequately monitor his renal function when prescribing diclofenac to him, the GP did not provide services with reasonable care and skill and therefore breached Right 4(1). The GP breached Right 6(1)(b) because the risks of diclofenac use compared with risks or benefits of alternative treatments were not discussed. Without this information the man was not in a position

to make an informed choice, and give his informed consent to taking the medication. Accordingly, the GP also breached Right 7(1).

Adverse comment was made about the medical centre for not ensuring that its computer systems were fully functioning or that a temporary system was in place for its doctors to follow, while the systems were undergoing changes.