Failure to diagnose: ectopic pregnancy

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Case histories are based on actual medical negligence claims, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Medical negligence claims alleging 'failure to diagnose' are a common cause of claims and complaints against general practitioners. This article outlines strategies to minimise the possibility of an adverse patient outcome arising out of a delay in diagnosis of ectopic pregnancy.

Case history

On 15 December 2001, Mrs Woods consulted her general practitioner, Dr Forbes, with a history of nausea, urinary frequency and dull lower abdominal pain. The patient, 35 years of age, had a history of endometriosis which had been confirmed by laparoscopy in 1995. She had previously undergone three cycles of in vitro fertilisation (IVF) in the late 1990s but these had been unsuccessful. She had no other significant medical history and was taking no regular medications. There was no history of fever, dysuria or gastrointestinal symptoms. Abdominal examination was unremarkable. Urinalysis revealed blood +++. Dr Forbes made a provisional diagnosis of an urinary tract infection. He ordered a midstream urine test (MSU) and prescribed a course of oral cephalexin. Three days later, Mrs Woods returned for review. She reported that the abdominal pain was unchanged, but her period had just commenced. The nausea was still present but the urinary frequency had improved. The MSU did not reveal any growth. Dr Forbes recommended that the patient stop the antibiotics and wait and see if her symptoms settled with the onset of her period. The following day, on 19 December 2001, the patient re-presented with increasingly severe lower abdominal pain that was now radiating to the left iliac fossa. Abdominal examination revealed some tenderness in the lower abdomen and left iliac fossa with some mild guarding. At this time, the GP considered the possibility of an ectopic pregnancy. He ordered a serum beta-hCG and pelvic ultrasound. He asked the patient to return for review once these tests had been completed. He also advised the patient to attend hospital if her abdominal pain worsened. The patient rang the radiology practice and was informed that the earliest appointment for a pelvic ultrasound was on 22 December 2001. The patient made the appointment for the ultrasound and also attended the pathology collection laboratory for the blood test. The serum pregnancy test was positive, and the result was received by Dr Forbes on 21 December 2001. The GP contacted the patient by phone to advise her of the 'good news'. He stressed the importance of undergoing the pelvic ultrasound to make sure that everything was okay. The patient said her abdominal pain had improved slightly and confirmed that she had booked the ultrasound for the following day. On the night of 21 December 2001, the patient experienced excruciating pain in the left lower abdomen. She collapsed at home and her husband called an ambulance. Soon after her arrival in the emergency department a diagnosis of a ruptured left ectopic pregnancy was made. The patient subsequently underwent an emergency laparotomy and salpingectomy.

In September 2003, the patient commenced legal proceedings against Dr Forbes alleging a failure to diagnose ectopic pregnancy.

Medicolegal issues

In her Statement of Claim, the patient claimed that Dr Forbes had negligently failed to diagnose her ectopic pregnancy. As a result of this negligence, Mrs Woods alleged she had suffered unnecessary pain and suffering, unnecessary abdominal scarring including an incisional hernia, reduced fertility due to the ruptured left fallopian tube and salpingectomy, and emotional trauma.

The patient sought compensation for general damages and future medical expenses including repair of the incisional hernia and IVF treatment. In support of her claim, the patient served the report of an obstetrician and gynaecologist. This report stated that the standard of care provided by Dr Forbes was inadequate. The expert was critical of the GP's failure to consider the possibility of an ectopic pregnancy during the first two consultations, failure to obtain an adequate history of the abdominal pain, and failure to perform a speculum and bimanual pelvic examination. Once the diagnosis of an ectopic pregnancy was considered, the expert was critical of Dr Forbes' failure to look for signs indicating acute intra-abdominal bleeding (raised pulse and lowered blood pressure) and to refer the patient to hospital and/or for an urgent pelvic ultrasound. According to the expert, the positive pregnancy test and findings of left sided abdominal tenderness and guarding meant that the diagnosis of ectopic pregnancy required urgent consideration. The report concluded: 'There is a direct link between the failure to diagnose the presence of the ectopic pregnancy by Dr Forbes and the ultimate tubal rupture, salpingectomy and the likely future diminution of fertility'.

Expert opinion obtained on behalf of Dr Forbes noted: 'Mrs Woods would have required an operation in any case and the option of conservative laparoscopic management rather than laparotomy may not have been available or appropriate for her. The patient had a past history of endometriosis, subfertility and IVF treatment. I do not believe that the left salpingectomy has had any effect on her fertility. In the presence of two normal ovaries and a right fallopian tube, the plaintiff's fertility is not compromised. Her fertility is certainly not halved by the absence of one tube. The presence of a single functioning fallopian tube and ovulation from either ovary gives the patient a fertility profile that was present before the surgery'. The expert went on to conclude: 'Even though I have serious doubts that the failure to diagnose the ectopic pregnancy before rupture has significantly affected the plaintiff's subsequent medical symptoms I feel that it would be difficult to defend the question of the missed diagnosis of ruptured ectopic pregnancy. I am concerned that Dr Forbes did not consider the possibility of pregnancy at the consultations on 15 and 18 December 2001. I am also critical of his failure to recognise the potential surgical emergency of a ruptured ectopic once the plaintiff's pregnancy was confirmed on 21 December 2001'.

Following consideration of the expert reports, the claim was settled out of court in June 2004 in the amount of $30 000 inclusive of the plaintiff's legal costs.

Discussion

Medical negligence claims alleging 'failure to diagnose' a surgical condition such as ectopic pregnancy, appendicitis or testicular torsion are not uncommon. A review of claims data reveals common underlying themes:

- failure to consider the possibility of the final diagnosis or maintain a high index of suspicion for the condition
- atypical presentation of the condition
- failure to obtain a complete or adequate history or perform an appropriate physical examination
- failure to order and/or follow up test results and investigations.

In this case, the GP initially did not consider the diagnosis of an ectopic pregnancy as part of his differential diagnosis of the patient's presenting symptoms. The patient's past history of infertility undoubtedly contributed to this. Nevertheless, the possible diagnosis of pregnancy should be considered in any female patient of childbearing years, no matter how remote the possibility. Any patient in the early stages of pregnancy, or of childbearing age, who presents with abdominal or pelvic pain should be carefully evaluated for the presence of an ectopic pregnancy.

Risk management strategies

Ectopic pregnancy occurs at a rate of about 11 per 1000 diagnosed pregnancies.[1] The 'classic' picture of ectopic pregnancy includes abdominal pain, history of amenorrhoea and vaginal bleeding. The diagnosis of ectopic pregnancy is often difficult and early presentation may be atypical. It has been estimated that up to 50% of ectopic pregnancies are misdiagnosed at the initial presentation.[2] A failure to identify risk factors has also been reported as a significant reason for misdiagnosis. Risk factors for ectopic pregnancy include:

- pelvic inflammatory disease
- previous ectopic pregnancy
- endometriosis
- previous tubal or pelvic surgery
- infertility, and infertility treatments
- uterotubal anomalies
- cigarette smoking.[3]

Identification of these risk factors can increase the index of suspicion and lend significance to otherwise minor symptoms and physical findings.

Summary of important points

- The possibility of pregnancy should be considered in any female patient between menarche and menopause.
- Any patient in the early stages of pregnancy, or of childbearing age, who presents with abdominal pain and/or vaginal bleeding should be carefully evaluated for the presence of an ectopic pregnancy.

Conflict of interest: none.

References

1. Cameron P, Jelinek G, Kelly A-M et al, editors. Textbook of adult emergency medicine. 2nd ed. Edinburgh: Churchill Livingstone, 2004.
2. Abbott J, Emmans L, Lowenstein S. Ectopic pregnancy: ten common pitfalls in diagnosis. Am J Emerg Med 1990;8:515–22.
3. Tenore J. Ectopic pregnancy. Am Fam Physician 2000;61:1080–8.

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