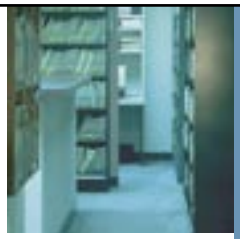
Failure to diagnose: renal disease



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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. This article discusses a claim arising out of the failure to diagnose glomerulonephritis and examines the legal concepts of causation and loss of chance.

Case history

The 36 year old accountant presented to his general practitioner in November 2000 complaining of severe testicular pain. The GP referred the patient to the local emergency department for assessment and exclusion of torsion of the testis. At hospital, a provisional diagnosis of orchitis was made and the patient was commenced on oral antibiotics. Between December 2000 and February 2001 the patient re-presented to the GP on several occasions complaining of dysuria and testicular pain. There was no penile discharge. A chlamydia polymerase chain reaction was negative. Full blood count was normal, and electrolyte, urea and creatinine (EUC) revealed urea 10.1 mmol/L (normal range 2.0–7.0) and creatinine 0.13 mmol/L (normal range 0.02–0.12). A midstream urine (MSU) reported blood cells 10–100/cmm, protein ++, hyaline casts but no growth on culture. The GP organised an intravenous pyelogram which was reported as normal. The GP decided to refer the patient to a urologist for further assessment. He provided the patient with a referral and enclosed copies of the pathology and imaging reports.

In March 2001, the patient was seen by the urologist. The urologist noted the history of microscopic haematuria and recommended a cystoscopy. The cystoscopy was normal. The urologist sent a brief report of the procedure to the GP with no further recommendations regarding management.

In April and May 2001, the patient returned to the GP complaining of testicular pain and urinary frequency. A further MSU was performed, which again revealed microscopic haematuria and proteinuria ++. There was no growth on culture. The GP prescribed further antibiotics for presumed orchitis. There were subsequent consultations for a respiratory tract infection and sprained ankle in June 2001. The patient did not consult the GP after this time.

In December 2002, the GP received correspondence from a renal physician stating that the patient had been diagnosed with glomerulonephritis and malignant hypertension. The patient subsequently developed end stage renal failure and commenced haemodialysis in December 2003.

In 2004, the patient commenced legal proceedings against the GP and the urologist alleging a delay in diagnosis of IgA nephropathy.

Medicolegal issues

In his Statement of Claim the patient (now a plaintiff) alleged that the GP (now the first defendant) and the urologist (now the second defendant) breached their duty of care:

- failed to diagnose IgA nephropathy
- failed to properly or at all investigate the plaintiff for IgA nephropathy
- failed to properly treat the IgA nephropathy
- failed to refer the plaintiff to a renal physician.

Particulars of the injuries and disabilities suffered by the plaintiff included:

- malignant hypertension
- deterioration in the plaintiff's vision
- renal failure
- requirement for haemodialysis and renal transplantation
- higher risk of death.

Expert opinion served on behalf of the plaintiff included a report by a GP. The GP concluded that a renal cause for the patient's presentation should have been considered by the GP and the urologist. The expert stated that: 'important clues were the presence of blood and also albumin in the two MSU results. The presence of hyaline casts in one of the reports was highly suggestive of an underlying renal cause. The elevated urea and creatinine in February 2001 indicated the patient already had significant impairment of kidney function and an active glomerulonephritis as evidenced by the presence of microscopic haematuria, proteinuria and the presence of hyaline casts'.

The GP was also critical of the failure of the GP to record a blood pressure reading at any of the consultations with the patient. The only blood pressure reading included in the voluminous records sent to the expert was that taken on the day of the cystoscopy when the patient's blood pressure was noted to be 130/85.

Expert urological opinion was critical of the urologist's management of the patient. The plaintiff's expert urologist concluded that: 'by current professional standards, a urologist who recognised that the patient had persistent microscopic haematuria would exclude the stigmata of renal parenchymal disease, namely proteinuria, elevated blood pressure and/or serum creatinine. If any of these were abnormal, then it would have been appropriate to refer the patient for further investigation. It is not within the province of urological expertise to make a further diagnosis other than to recognise the stigmata of renal parenchymal disease and make an appropriate referral'.

The defendant GP's medical defence organisation sought an expert opinion from a GP. The GP concluded that: 'there are two pathways with respect to the investigation of microscopic haematuria. If it appears that there may be a surgical cause for the microscopic haematuria, then referral to a urologist is the preferred path. If there is no obvious surgical cause, then referral to a renal physician would be the preferred path. In this case, with the history of orchitis, referral to a urologist was not unreasonable'.

The GP went on to state: 'unfortunately two separate conditions were present, both involving the urinary system, which blurred the issues. One obvious condition was the infected testicle with the diagnosis of orchitis, which can result in ongoing microscopic haematuria. The other process that was undoubtedly occurring was that of renal disease. Regular monitoring of the patient's renal function and micro-urine as well as his blood pressure should have been carried out over the ensuing few months. If any abnormality persisted in any one of these variables, a referral to a renal physician should have been undertaken. Unfortunately the atypical nature of the patient's symptoms, the mildly abnormal blood and urine test results combined with the urologist's reassuring reports persuaded the GP that further investigation was either not required or would be managed by the urologist'.

Both defendants obtained an expert report from a renal physician to address the issue of causation – the nexus between the alleged breach of duty of care and the plaintiff's injuries. In essence, did the alleged delay in diagnosis of glomerulonephritis cause the injuries claimed by the plaintiff? In this respect, the expert noted that: 'IgA nephropathy is the commonest form of glomerulonephritis leading to end stage renal failure. However, not all cases tend to progress. Approximately one-third of patients will develop progressive renal impairment while the remainder may follow a benign course for many years. Overall, it has been estimated that approximately 6% of patients with IgA nephropathy will have serious renal failure within 5 years of diagnosis while about 14% will be in a similar position at 10 years. A subgroup will develop renal failure more rapidly. It is likely that the patient would have developed end stage renal failure regardless of what treatment was given, but earlier diagnosis would have resulted in a slower progression. It is impossible to say how much delay in progression of the renal disease would have been achievable as it is impossible to predict the rate of progression of renal disease'.

The claim proceeded to mediation and settled for $350 000 inclusive of plaintiff legal costs. Settlement was ultimately apportioned 40% to the GP and 60% to the urologist.

Discussion and risk management strategies

Up to 50% of the medical negligence claims against GPs involve an allegation of 'failure to diagnose'. In these claims the patient/plaintiff alleges that an earlier diagnosis would have resulted in a better outcome in terms of treatment and prognosis and therefore they should be entitled to an award of damages to compensate for the loss of a chance of a cure or better outcome. 'Common sense' suggests that earlier diagnosis leads to a better outcome for the patient, but this is not inevitably the case. Medical causation relies on scientific proof whereas legal causation depends on probabilities and notions of 'common sense'.

In this claim, the patient had to establish, on the balance of probabilities, that the delay in diagnosis of his glomerulonephritis caused him injury and damage. The patient was able to establish that his uncontrolled hypertension caused visual problems and that the delay in diagnosis and management of his glomerulonephritis hastened the need for dialysis. However, it appeared that the patient was always going to be part of the cohort of patients with IgA nephropathy who would progress to renal failure, even with appropriate therapy. Accordingly the settlement amount was discounted to exclude the costs of long term dialysis and renal transplantation because this treatment was required for the underlying condition and was not affected by the negligent delay in diagnosis of the glomerulonephritis.

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