Please be aware that this is an anonymised copy of what was a real report and litigation has ended. The names in this report are all false.

Medical Report by Dr Alastair H Bint

Dated
3rd May 2010

Area of Expertise
General Practice

On behalf of the Claimant
Mr Brown husband of deceased Mrs Susan Brown
XXXXXXXXX

Instructing Solicitors
Jackaman, Smith and Mulley,
XXXXXXXXXXXXXXXXXXXXXX
Ref XXXXXXXXXXXXX

Subject
Failure to diagnose spread of breast cancer to the spine.

Written by
Dr Alastair Bint, St Lukes Surgery, Warren Road, Guildford, UK, GU13JH

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Appendices

Report

1. Introduction

1.01 The Expert

I am Dr Alastair Halford Bint. My specialist field is General Medical Practice. Full details of my qualifications and experience entitling me to give expert opinion evidence in this case are in appendix 1.

1.02 Summary background of the case

Mrs Susan Brown had a history of breast cancer and during late 2008 she presented several times to her General Practitioner (GP), Dr Pink, with back pain. It was not until six weeks later that she presented to Accident and Emergency and a spinal tumour, spread from her breast cancer, was diagnosed. Since then she was left housebound and in need of 24 hour care and then passed away in mid December 2008.

1.03 Summary of my conclusions

It is my opinion that the care afforded to the late Mrs Brown by her GPs was reasonable. Her breast cancer was diagnosed quickly, she was put on the right treatment and had appropriate follow up. Sadly, it is a tragic character of breast cancer that it can spread very late into the disease process and it can be many years between initial diagnosis and the metastatic spread to bones. There was not an unreasonable delay in the diagnosis of the bone metastasis and I can find no material breaches in duty of care from a General Practice point of view that will have contributed to her death.

1.04 The parties involved

Mrs Susan Brown (deceased)
Mr Brown husband of deceased, Claimant
Dr Pink, GP of The Health Centre, XXXXXXXXXXXX; Defendant.

1.05 Technical terms and explanations

I have indicated any technical terms in **bold type**. I have defined these terms when first used and included them in a glossary in appendix 3. I have explained common medical abbreviations in brackets within the text of the report. In appendix 4 I have identified any references to published works as identified during the report by a superscripted number.

2 The instructions and issues raised

2.01 To comment on whether the treatment afforded to the late Mrs Brown by her GP contributed to or caused her subsequent death.

2.02 Whether previous breast adipose tissue noted in the left axilla should have highlighted Mrs Brown as 'at risk'.

2.03 To comment on the appropriate steps which should have been taken by the GP with regards the back pain that Mrs Brown was suffering from April to October 2009.

2.04 What steps the GP should have taken to monitor Mrs Brown from November 1999 through to 2008.

2.05 My opinion on the prognosis and difference of treatment had the GP acted at an earlier date with regards the recurring malignancy (spinal metastasis)

2.06 Any general criticisms I may have regarding the care as provided by GP Dr Pink.

3 My investigation of the facts, history of events

3.01 Prior to the following events, Mrs Brown (Sampson) was a fit and well lady and was aged 30 years when she first presented to Dr Pink of XXXX Health Centre, XXXXXX.

3.02 In January 1987, Dr Pink referred Mrs Brown to a Plastic Surgeon because of an ongoing swelling in the left armpit. She was seen by a surgeon and an agreement was made to remove the tissue. After considerable delay, and a reminder letter from Dr Pink the lump was removed in July 1991. The subsequent histology report showed Fibro-adipose tissue, containing benign breast epithelial elements with no evidence of **neoplasia**.

3.03 Over the next few years Mrs Brown consulted her GP a few times for various relatively inconsequential issues, including varicose veins. However, on 19th January 1998, Mrs Brown consulted Dr Pink regarding a left sided breast lump that she had discovered. Dr Pink managed to aspirate 20 millilitres of clear fluid from the lump and referred Mrs Brown to Mr Flamingo, Consultant Breast Surgeon at The West Suffolk Hospital and a referral letter was sent on the 21st January 1998.

3.04 A letter addressed to Dr Pink, written from Dr K Red, Breast Clinical Specialist, dated 10th February 1998 states that Mrs Brown had a normal mammogram, an ultrasound that showed a cyst, which was aspirated by Dr Ingram. The letter finishes by stating, '*we would be very happy if you were able to aspirate any cysts that may develop in the future. We don't routinely organise mammograms on lady's with cysts but will, of course, be happy to*

see her if you are unable to aspirate a cyst or there are any other suspicious features.'

3.05 Mrs Brown represented to Dr Pink on the 11th October 1999 with a further left sided breast lump. The next day, Dr Pink sent an urgent referral letter to Mr Purple, Consultant Surgeon, The West Suffolk Hospital. In the letter he stated his fear that this was likely to be a breast malignancy.

3.06 Core biopsy histology taken a week or so later confirmed Grade 2 Carcinoma. This was described by the surgeon as an enormous cancer. It was felt to have spread to two nodes in her armpit but scans of her liver and a bone scan had been clear. Mrs Brown received six cycles of chemotherapy to shrink the cancer and then proceeded to a full left mastectomy in April 2000, with axillary node clearance. Further to that she then received radiotherapy postoperatively. The cancer was showed to be Oestrogen receptor positive, meaning she was eligible for the chemotherapy agent, Tamoxifen for 5 years following the surgery, which is a medication aimed at increasing survival rates and reducing metastatic spread.

3.07 Mrs Brown opted to have a right-sided prophylactic mastectomy, which was performed in September 2001.

3.08 Thereafter, Mrs Brown was followed up by the breast oncology team, initially 6 monthly and then annually until January 2005. She continued on Tamoxifen, which was discontinued by the breast specialist in January 2005 and replaced by Arimidex, which was to be continued for 5 further years. By the date of discharge from clinic follow-up in January 2005, there had been no suggestion of breast cancer recurrence and it was felt that there was little point with ongoing clinical examination of the breast as there was no breast tissue remaining. No clinic letters mention any bony pain or any need to perform bone scans to check for metastatic bony spread of the breast cancer.

3.09 In December 2005, Mrs Brown consulted Dr Pink, having suffered an episode of postmenopausal vaginal bleeding. Dr Pink referred Mrs Brown urgently to a Gynaecologist and subsequent investigations were normal.

3.10 Thereafter, until April 2008, there is little relevant contact between Mrs Brown and her GP. There were some consultations relating to her blood pressure, travel vaccinations and an injury to her toe.

3.11 On the 24th April 2008, there is the first recorded consultation between Mrs Brown and Dr Pink, relating to back pain. The records state, '*Backache-sounds mechanical ?lifting, between shoulder blades.'* Examination is simply recorded as '*NAD*' (Nil Abnormal Detected). No treatment or follow up is documented.

3.12 Thereafter there are two further consultations with Dr Pink, one relating to varicose veins and one relating to travel vaccinations. Neither consultation mentions back pain, until 14th August 2008 when Mrs Brown consulted Dr Pink again and the clinical notes read, *'a week now discomfort around left*

scapula.' Examination was recorded as, '*no rash, spine fine'* and Ibuprofen anti-inflammatory medication was prescribed.

3.13 Mrs Brown returned to see Dr Pink on the 28th August 2008 because the pain hadn't settled, it had become more generalised and was worse when she woke. Dr Pink recorded the examination as, '*normal spine, lung fine, full movement.*' He concluded that this sounded very muscular and suggested local gel treatments.

3.14 On the 10th September 2008, Mrs Brown returned again because the pain had now moved around to the right breast area. Dr Pink examined the area and stated that it was *'ok'* and prescribed Diclofenac painkillers. He advised a new bed, and made a note to '*refer if no better after new bed.'*

3.15 On the 15th September 2008, Mrs Brown returned to the GP, consulting Dr Yellow on this occasion. Dr Yellow noted that the pain continued but eased when she got up and walked around. Mrs Brown was suffering diarrhoea with the Diclofenac so Dr Yellow changed the medication to Naproxen, another anti-inflammatory painkiller. Dr Yellow noted that there was no bony tenderness on examination.

3.16 On the 29th September 2008, Mrs Brown telephoned Nurse Jan Kelly at the GP Practice as she was concerned regarding the ongoing mid back pain. Nurse Kelly stated in the notes, '*real concern is that she may have mets* (metasteses) *from previous breast ca* (cancer).' Nurse Kelly arranged an x-ray.

3.17 The x-ray report was received by the GP on the 29th September 2008 and was reported by Radiologist Dr Indigo. It suggested there might be a metastatic deposit in the vertebra. Dr Pink acted on this immediately and he wrote a referral letter to Dr White, Consultant Clinical Oncologist at Ipswich Hospital, on that same day. At the top of the referral letter, Dr Pink had written and underlined in bold, '*urgent appointment please.*' In the event, no appointment was received by Mrs Brown prior to her emergency hospital admission as detailed below.

3.18 It appears that Nurse Green telephoned Mrs Brown the next day to advise her about the oncology referral and also suggested a change in painkillers.

3.19 On the 1st October 2008 Mrs Brown consulted Dr Pink and he noted that she was really anxious because of the abnormal x-ray result. This was the last time Dr Pink saw Mrs Brown before she suffered the vertebral collapse.

3.20 Thereafter there were several consultations with GPs over the next ten days, mainly relating to adequate pain control and the constipating side effects of some of the painkillers and itchiness side effects of others. All of these consultations were with HMS Medicall, an out of hours medical call centre. In these consultations documented on 1st October, 2nd October, and 4th October 2008, there is no mention of symptoms suggestive of spinal cord compression or impending vertebral collapse.

3.20 On the late evening of the 9th October 2008, Mrs Brown telephoned HMS Medicall due to ongoing pain and trouble walking, and she was visited by Dr Turquoise at 22.30 hrs that night. Dr Turquoise was concerned that there was spinal cord compression and arranged for immediate transfer to Ipswich Accident and Emergency Department.

3.21 Within a couple of days, Mrs Brown was transferred to Addenbrookes Cambridge University Hospital. A CT scan performed showed extensive metastatic breast disease, throughout her liver, chest and axillary lymph nodes, spine and upper arm bones. She was treated with radiotherapy to her upper arm but the consensus from the neurosurgical team was that it was too risky to operate on her spine as it may have made things worse. Miss Blue, Consultant Neurosurgeon, summarised the situation in her letter to Dr Black, Consultant Oncologist, stating, '*to take out her spinal breast disease would be quite a major undertaking and would require quite an extensive laminectomy for what would be of moderate benefit….as neurological deficit is mostly irreversible…I understand that subsequent investigation has revealed extensive disease elsewhere, which make the decision not to operate even more appropriate.'*

3.22 Thereafter Mrs Brown changed GPs and registered with Dr Gray of XXX Health Centre in November 2008. From then until her death Mrs Brown was treated palliatively. She received palliative chemotherapy designed to shrink the cancers but not cure them. She was essentially wheelchair bound and catheterised. The GPs involved in her care dealt with pain control, catheter problems and treatments for a pulmonary embolism that she suffered late November 2008.

3.23 Mrs Brown died on the 16th December 2008.

4 My opinion

4.01 My opinion relating to the various aspects of this case is set out chronologically in order to answer each of the specific instructions as detailed in paragraph 2.

4.02 After a thorough review of the records in this case, it is my opinion that the care afforded to the late Mrs Brown by her GPs was reasonable. Her breast cancer was diagnosed quickly, she was put on the right treatment and had appropriate follow up. It is a sad tragedy of breast cancer that it can spread very late into the disease process and it can be many years between initial diagnosis and the spread to bones. I can find no material breaches in duty of care from a General Practice point of view that will have contributed to her death.

4.03 The lump excision from the left armpit back in 1991, the histology of which showed some breast epithelium, is of no relation to the breast cancer and has no association with being at risk of breast cancer.

4.04.1 For information, the commonest place for breast cancer to metastasise to is bone and commonly this is the spine. Having said that, spinal metastases only occur in 4% of patients with metastatic breast cancer.[1] 24% of all spinal metastasis come from the breast.[2] Although spinal and bony metastasis is therefore relatively uncommon in patients with a history of breast cancer, one should never discount the possibility. However, one must also remember that bony metastasis as a cause for back pain in patients with a history of breast cancer is still not even remotely as common as muscular pain or osteoarthritis is as a cause. Therefore, the decision to refer a patient for further investigation is based on the severity and the persistence of pain.

4.04.2 Mrs Brown did consult Dr Pink several times with back/shoulder blade pain before she was referred for an x-ray and then for further investigation, but it was not felt to be particularly severe and the persistence could only be established by the passage of time. Although it did take several visits to be referred for an x-ray, the total time span covering the bulk of the visits was just six weeks and during those visits Dr Pink did try some reasonable treatments and suggestions for example, changing bed and trying a different anti-inflammatory painkiller. In my opinion, these time delays were not unreasonable nor were the suggested treatments. In this regard, it is my opinion that Dr Pink acted within the expectation of an ordinary and reasonable clinician.

4.05 Regarding the monitoring steps that one would expect to have been performed by the GP from November 1999-2008. Mrs Brown was under follow up from the breast oncology department of the hospital and it is reasonable for a GP to expect that the primary follow up would be by them. After being given the all clear and discharge from follow up in early 2005, the standard monitoring in these circumstances is very much based on an 'as required' basis. This is to say that symptoms would be managed reactively, without there being any specific screening tests for metastatic disease. In this regard therefore, the care and follow up monitoring provided by the GP was within normal and reasonable practice.

4.06 It should also be noted, that the nature of breast cancer metastases is that they are often very slow growing, and it is entirely possible that some of the metastases may well have been present, but very much smaller, during the time that Mrs Brown was being followed up by the breast oncology clinic, but without any symptoms there would have been no reason for them to have been suspicious or alerted to their presence.

4.07 Had Dr Pink acted with more speed and referred Mrs Brown for an x-ray and assessment sooner, it is very possible that the sudden vertebral collapse requiring emergency neurosurgical intervention may have been avoided. Had this been avoided, Mrs Brown may have continued to have the use of her legs. The loss of the use of her legs may have defined a psychological low point for

Mrs Brown, but it should be noted that whether the vertebral collapse would or would not have happened had the GP acted sooner, it is unlikely to have particularly affected the overall prognosis and disease progression which led to her eventual death. This is because the disease was already very advanced having spread to the liver and elsewhere. The point however, is that there is no way that any clinician could have predicted the sudden vertebral collapse and as stated in paragraph 4.04.2, the delay in investigation was, in my opinion, within reasonable practice. The sudden unexpected vertebral collapse and its consequences was simply an unpredictable and tragic event.

4.08 In my opinion, the general management and care provided by Dr Pink appears to have been of a reasonable standard and I do not have any general criticisms.

5 Statement of compliance

(a) I understand that my overriding duty is to assist the Court in matters within my expertise, and that this duty overrides any obligation to those instructing me or their Clients. I confirm I have complied with that duty and will continue to do so, I am aware of the requirements set out in Part 35 of the Civil Procedure Rules and the accompanying Practice Direction, the Protocol for the Instructions of Experts to give Evidence in Civil Claims, and the Practice Direction for Pre-action conduct.

(b) I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

(c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.

(d) I consider that all the matters on which I have expressed an opinion lie within my field of expertise.

(e) I have drawn to the attention of the court all maters, of which I am aware, which might adversely affect my opinion.

(f) In preparing and presenting this report I am not aware of any conflict of interest actual or potential save as expressly disclosed in this report.

(g) In respect of matters referred to which are not within my personal knowledge, I have indicated the source of such information.

(h) I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

(i) Where, in my view, there is a range of reasonable opinion relevant to the opinions I express, I have indicated the extent of the range in the report.

(j) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any alteration, correction, or qualification.

(k) I understand that this report will be the evidence that I will give, if required, under oath, subject to any correction or qualification I may make before swearing to its veracity.

(l) I have attached to this report a statement setting out the substance of all the facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

6 Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matter to which they refer.

Signed by Dr Alastair Bint

Dated 3rd May 2010

Appendix 1

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My experience and qualifications:

I am a full time NHS GP in a practice with a 10,000 patient population and I am a trainer of foundation doctors in General Practice. I am Chairman of the South West Thames faculty of the Royal College of General Practitioners and I sit on the executive committee for postgraduate General Practice education in Kent, Surrey and Sussex. I work as a clinical lead and have sat on the Guildford Practice Based Commissioning board, one of the roles of which is appraising clinical pathways and protocols. I am a commentator for the Royal College of GPs on professional regulatory and medico-legal issues.

In relation to this case, I have received postgraduate training and experience working in both hospital based breast cancer care and oncology care, at the Western General Hospital in Edinburgh and the Royal Surrey County Hospital St Lukes Cancer Centre.

Qualifications:
- MBChB, Bachelor of Medicine and Bachelor of Surgery, Edinburgh, 1998
- Advance life support; ACLS (1999), ATLS (2000), PALS and APLS (2001).
- DGM, Diploma in Geriatric Medicine, Royal College of Physicians, 2001
- DRCOG, Diploma from Royal College of Obstetricians and Gynaecologists, 2002.
- DFSRH, Diploma from Faculty of Sexual and Reproductive Healthcare, 2002
- FRCGP, Membership of Royal College of General Practitioners, 2003, Fellowship elected 2009.
- MEWI, Membership of Expert Witness Institute 2008.

Memberships:
- General Medical Council number 4546883
- Medical Defence Union number 307265G
- Royal College of General Practitioners number 53602
- Faculty of Sexual and Reproductive Healthcare number D015276
- Expert Witness Institute number 1776

Appendix 2

List of documents examined

Letters of instruction from Jackaman Smith Mulley dated 8th January and 25th March 2010.

Full GP records from XXXXXXX and XXXXXXXX Health Centres.

Hospital records from Addenbrookes Hospital, Cambridge, Ipswich Hospital and West Suffolk Hospital

Appendix 3

Glossary of terms used

Neoplasia; general term meaning cancer.

Scapula; shoulder blade.

Appendix 4

Sources of references to published works

1. Reiki Nishimura, Kazuharu Nagao, et al, 'Diagnostic problems of evaluating vertebral metastasis from breast carcinoma with a higher degree of malignancy' *Cancer Journal* Volume 85 issue 8 pages 1782-88 November 2000.

2. Victor T, 'Spinal Metastasis and Metastatic Disease to the Spine and Related Structures'. Associate Professor, Department of Neurosurgery, Stanford University Medical Centre, Santa Clara Valley Medical Centre.