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

To the Court

Dated
18th October 2011.

Area of Expertise
General Practice

On behalf of the Claimant
Mrs Hannah Blue,
XXXXXXXXXXXXXXXXX.
Date of birth XXXXXXXXXXX

Instructing Solicitors
O'Mahony Farrelly and O'Callaghan Solicitors
Wolfe Tone's Square, Bantry, County Cork, Ireland.
Ref XXXXXXXXXXX

Subject
Colon Cancer

Written by
Dr Alastair Bint, 25 Danesfield, Ripley, Surrey, GU23 6LS

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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 Blue suffered bowel problems and anaemia and underwent a colonoscopy in late 2006 which was reported as normal. She visited her General Practitioner (GP) several times and an ongoing iron deficiency was noted as well as blood in her motions. It was not until mid 2009 when she underwent the removal of a vaginal polyp that a colorectal cancer was discovered that had already spread to the liver.

1.03 Summary of my conclusions

In summary, despite an apparently normal colonoscopy in late 2006, Mrs Blue presented to Dr Pink with a persistent iron deficiency anaemia that was inadequately explained and with ongoing symptoms of blood in her motions. By December 2007 upon the second report of blood in her motions it is my opinion that an ordinary GP acting with ordinary care should have referred Mrs Blue back to a Gastroeterologist for further investigation. For the avoidance of doubt, it is my opinion that the failure of Dr Pink to refer Mrs Blue was outside the standards of care expected of an ordinary GP acting with ordinary care.

1.04 The parties involved

Mrs Hannah Blue; Patient and Claimant
Dr Colin Pink; General Practitioner and Defendant.

1.05 Technical terms and explanations

I have indicated any technical terms in ***bold italic 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. Direct quotes from records are in *italic* script.

2 The instructions and issues addressed

2.01 To comment on the standard of care provided by the General Practitioner in relation to the bowel symptoms in Mrs Blue and the eventual diagnosis of colorectal cancer.

3 My investigation of the facts, history of events

3.01 On the 3rd May 2006 Mrs Hannah Blue consulted her GP Dr Colin Pink regarding some blood in her faecal motions. Dr Pink recorded that there was nothing on rectal examination but concluded the cause was '*probable haemorrhoids'*.

3.02 Over the next few months Mrs Blue returned to consult Dr Pink on a few occasions with heartburn symptoms and with a swelling under her tongue. On the 11th September 2006 Dr Pink referred Mrs Brown to Dr William Stack, Consultant Gastroenterologist for his opinion.

3.03 The clinic letter dated the 14th September 2006 from Dr Red to Dr Pink noted, '*Many thanks for referring this 45 year old lady who has upper and lower GI symptoms which have been ongoing for some time now. She has a history of chronic dyspepsia and heartburn…she has also had an irregular bowel habit with alternating constipation and has had episodic rectal bleeding which has been attributed to piles over the last few months.*' Dr Stack stated that he suspected Mrs Blue had oesophageal reflux and probably irritable bowel syndrome.

3.04 On the 26th October 2006 Dr Red wrote to Dr Pink to advise that a colonoscopy was normal but that blood tests had revealed an anaemia with a haemoglobin of 8.5 g/dl (normal is above 12) with an iron deficiency pattern. Duodenal biopsies had been normal ruling out an iron malabsorption syndrome to account for the iron deficiency. Dr Stack advised, '*I am happy to have ruled out significant GI pathology for this.*' Dr Stack advised Dr Pink to prescribe iron and recheck the haemoglobin in a few months. Dr Stack concluded with, '*please let me know if I can be of further help with her.'*

3.05 Dr Pink arranged for Mrs Blue to receive iron injections. On the 21st December 2006 a blood test revealed a haemoglobin of 9.1 g/dl (low) and a ferritin level (iron level) of 11 ng/ml (low, with normal being above 17). It was noted by the GP that the haemoglobin was low but it was also noted that Mrs Blue suffered heavy menstrual periods.

3.06 Regarding the heavy periods Mrs Blue was then started on the oral contraceptive medication, Yasmin in order to control the flow.

3.07 Iron injections were continued with the final one being administered on the 17th January 2007. Thereafter Mrs Brown received oral iron rather than injections. On the 26th January 2007 a blood test revealed a haemoglobin of 11 (still low) but a ferritin level of 29 (normal).

3.08 On the 3rd April 2007 a blood test showed a normal haemoglobin of 12.6 but a low ferritin of 11.

3.09 A statement from Mrs Blue advises that during 2007 her motions were irregular and she would have streaks of blood in the stools but no blood in the toilet bowl.

3.10 On the 17th October 2007 Mrs Blue consulted Dr Pink and the records note that Mrs Blue reported blood in her motions. Dr Pink noted that Mrs Blue had suffered gastroenteritis whilst in the Canary Islands after eating fish and prescribed antibiotics for a urinary tract infection and an ant-acid medication, Losec.

3.11 On the 11th December 2007 Mrs Blue re-consulted Dr Pink who noted that a stool occult blood was positive and diagnosed a thrombosed pile, which he later incised on the 25th January 2008.

3.12 The statement from Mrs Blue notes that she didn't go back to see Dr Pink every time she had rectal bleeding, '*she felt that she was annoying him and that he would simply say that she has irritable bowel syndrome and there was nothing really she could do.*'

3.13 Accordingly, throughout 2008 there were no consultations with Dr Pink relating to the rectal bleeding, in fact there were only two further consultations recorded throughout the whole of 2008, with one relating to a chest infection and the other relating to some urinary symptoms.

3.14 Mrs Blue has receipts for GP visits dated 17/08/07, 20/10/08 and 14/11/08 for which there appears to be no corresponding GP records.

3.15 On the 29th January 2009 a blood test revealed a haemoglobin of 9.7 (low) and a ferritin level of 5 (very low)

3.16 On the 17th February 2009 Mrs Blue consulted Dr Pink regarding the blood tests and Dr Pink recorded, '*note low iron again, see history of GIT* (gastrointestinal tract) *investigations, note has menorrhagia* (heavy periods), *no red meat, and IBS-so its probably a combination of all 3.*' Dr Pink re-instigated oral iron therapy.

3.17 The statement from Mrs Blue advises that her periods were always regular, they were sometimes heavy but that the contraceptive pill had lightened them.

3.18 Regarding diet, Mrs Blue has advised that she ate no meat but ate healthily, eating fish every day with plenty of fruit and vegetables.

3.19 Meanwhile in early 2009 a small vaginal polyp noted by the Practice Nurse had generated a Gynaecological referral to Dr Cathy Burke. This was excised in July 2009 but unfortunately the histology revealed that this was part of a colorectal cancer. Further investigation revealed an advanced colorectal cancer that had already spread to the liver.

4 My opinion

4.01 It has been mathematically estimated that by the time a liver metastasis is detectable on imaging it has already been present in the liver for more than 3 years.[1] This means that a colon cancer which has already metastasised by the time of diagnosis will have been present in the colon for well over 3 years. I am struck by the apparently normal colonoscopy performed in late 2006 and that the colon cancer was then diagnosed less than 3 years later and I advise that an expert Gastroenterologist or Colorectal Surgeon comment on the quality of this colonoscopy and the likelihood that there may well have been a colon cancer that could and should have been identified at that time.

4.02 Dr Pink was right to gain some reassurance from the apparently negative colonoscopy and studies have shown that the chances of developing a colon cancer within three years of a normal colonoscopy are lower than average. [2]

4.03 That said it is very clear from the blood results of January and April 2007 that Mrs Blue still had some form of pathological process which was causing an iron deficiency. To explain, in January 2007 she still had a low haemoglobin (i.e. she was still anaemic) despite having adequate iron replacement (causing a normal ferritin level). By April 2007 her haemoglobin had been brought up to normal but her iron level had already become depleted again, indicating an ongoing blood losing pathology.

4.04 There is no record that Dr Pink acted upon the abnormal blood results of April 2007 but in my view it was within a reasonable standard of medical practice to continue to monitor at this stage.

4.05 The problem is that on-going monitoring did not happen and it was not until nearly two years later in January 2009 that the next blood test was taken. Mrs Blue was shown to be iron deficient in April 2007 whilst either still being on iron replacement therapy or possibly having just finished it. Although it may at this stage have been reasonable to have attributed part of the iron deficiency to heavy periods (especially in view of the apparently normal colonoscopy), it was not reasonable in my view to fail to continue monitoring Mrs Blue's blood indices.

4.06 Usual and ordinary General Practice would have been to check the full blood count again in a further three months. If it was abnormal (as it surely would have been) then one would continue to check it on a three to four monthly basis until such time as it would be clear that re-investigation was necessary.

4.07 We know that by the next time the haemoglobin was measured in 2009 it was significantly low again and with a very iron deficient picture. It is very likely that the haemoglobin would have slowly deteriorated continually from the last recorded measurement in April 2007 until the next measurement in January 2009. Had Dr Pink measured the blood count in the interim period it is likely he would have identified an anaemia again and in my view the only reasonable option when identifying an anaemia would have been to re-investigate.

4.08 This failure to adequately monitor the blood count in Mrs Blue therefore represents a missed opportunity. It is however superseded to some degree by the events of late 2007 addressed in the following paragraphs.

4.09 There is a statement from Mrs Blue to advise that she suffered blood in her motions regularly and that Dr Pink advised it was caused by Irritable Bowel Syndrome. There are also GP receipts of visits to Dr Pink of which there are no corresponding notes so I do not know what transpired in those consultations and why Dr Pink would fail to record them. Failure to record consultations is considered poor practice as defined by the General Medical Council and the Medical Council of Ireland.

4.10 We do however have a very clear GP record made by Dr Pink in October 2007 relating to Mrs Blue suffering from blood in the motions. We also have a further note from December 2007 relating to a faecal occult blood test being positive (which translates as demonstrating blood in motions).

4.11 The notes appear to clearly show that Mrs Blue did have a haemorrhoid (pile) towards the end of 2007, which Dr Pink later incised. Piles do not cause blood in the motions, they cause some fresh blood on the toilet paper or some fresh blood in the toilet pan.[3]

4.12 Irritable Bowel Syndrome is a functional problem affecting bowel motility and does not cause any form of rectal bleeding or iron deficiency.[4,5]

4.13 Blood mixed in with stool has been clearly shown in studies to be of predictive value in identifying patients at higher risk of colorectal cancer.[6]

4.14 Dr Pink appears to have rationalized the October 2007 report of blood in the motions relating it to an attack of gastroenteritis Mrs Blue suffered whilst on holiday in the Canary Islands. Certain types of food poisoning (gastroenteritis) may cause bloody diarrhoea as part of the illness but most of this is self-limiting and does not cause the specific description of ‘streaks of blood in the stool’, which is very different to bloody diarrhoea.

4.15 By the 11th December 2007 we therefore have a verifiable and clearly documented picture in the medical records of a patient who has;

(a) attended her GP for at least the second time reporting blood in her stool.

(b) was iron deficient on her last blood count measurement despite having had iron replacement therapy.

(c) had a single thrombosed pile but this would not account for streaks of blood in the motions.

(d) had an episode of self-limiting gastroenteritis in the Canary Islands, which again would not account for ongoing blood in the motions.

(e) had a history of heavy periods but had been on the contraceptive pill Yamsin which had made them lighter.

4.16 In my view and on balance, at this stage a GP acting with ordinary care would have put together the iron deficiency and unexplained blood in the stool and seriously considered the possibility of a sinister bowel pathology despite the normal colonoscopy of fourteen months previously.

4.17 There is of course the argument that I refer to in Paragraph 4.02 of this report regarding the reassurance of a normal colonoscopy within the last three years, but in my view it was important, indeed essential, for Dr Pink to note several crucial things;

(a) the colonoscopy could be wrong and it was necessary for an ordinary Practitioner to consider this possibility.

(b) the colonoscopy could have innocently missed an early developing colon cancer,

(c) a negative colonoscopy a year before may make a colon cancer unlikely but it certainly would not rule it out, [7]

(d) the normal colonoscopy had still not adequately explained the iron deficiency.

4.18 Given all these points in paragraphs 4.15 and 4.17, in my view even with the benefit of hindsight, an ordinary GP acting with ordinary care should have referred Mrs Blue back to Gastroenterology for re-investigation in December 2007.

4.19 An expert Gastroenterologist or Colorectal Surgeon should comment on the likelihood that a colon cancer would have been identifiable in late 2007, early 2008 and an expert Oncologist should comment on the prognostic benefit that such earlier identification would have conferred.

4.20 Furthermore, in January 2009 Mrs Blue was shown to have a significant iron deficient anaemia and yet this still did not prompt further investigation by Dr Pink. Under English Two Week Rule suspected cancer referral guidelines an iron deficiency anaemia of this degree would generate an immediate referral to a Colorectal surgeon on the suspicion of colon cancer.[8] Although these guidelines are English, they are a reflection of international consensus.

4.21 Dr Pink appears to have rationalized this anaemia considering it 'probably' due to heavy periods (already addressed in this report), Irritable Bowel Syndrome (already addressed in this report) and a failure to eat red meat. Failing to eat red meat but still having a healthy diet with fresh vegetables is not generally associated with developing iron deficiency.[9]

4.22 In my opinion for Dr Pink to not refer Mrs Blue for Colorectal investigation at this stage was a failure to follow ordinary practice guidelines. The risk of colon cancer was significantly high enough that it simply could not and should not have been dismissed on a mere miscalculated probability of the iron deficiency being caused by heavy periods, IBS and lack of red meat.

4.23 Had Dr Pink even referred Mrs Blue to a Colorectal Surgeon at this later stage it would still have meant a referral eight months sooner than the cancer was eventually diagnosed. An Expert Oncologist could comment on the prognostic benefit a diagnosis eight months earlier would have conferred.

4.24 In summary, despite an apparently normal colonoscopy in late 2006, Mrs Blue presented to Dr Pink with a persistent iron deficiency anaemia that was inadequately explained and with ongoing symptoms of blood in her motions. By December 2007 upon the second report of blood in her motions it is my opinion that an ordinary GP acting with ordinary care should have referred Mrs Blue back to a Gastroeterologist for further investigation. For the avoidance of doubt, it is my opinion that the failure of Dr Pink to refer Mrs Blue was outside the standards of care expected of an ordinary GP acting with ordinary care.

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 their Clients or me. 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. I am also aware of my obligations under part 33 of the Criminal Procedure Rules. I have obtained the Bond Solon Civil Procedure Rules for Expert Witnesses Certificate to evidence my understanding and compliance with the above requirements.

(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 matters, 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.

PDF Digital signature for Dr Alastair Bint
Date: 18th October 2011.
Time: 07.43 hrs
Location: GB Expert General Practitioner offices
Serial number 3b 75 73 f0 8e 0a fe 95 0a df
Signature algorithm sha1RSA
Digital signature data encipherment; certification

Signed by Dr Alastair Bint

MBChB DGM DFSRH DRCOG FRCGP MEWI PGCert

Dated 18th October 2011.

Appendix 1

Consulting room: St.Lukes Surgery,
Warren Road, Guildford,
GU1 3JH.

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 sat on the executive committee for General Practice postgraduate training for Kent, Surrey and Sussex Deanery for 8 years. 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 currently sit on the joint GP revalidation board supporting GPs through the educational requirements of the revalidation process and I sit on the Fellowship committee overseeing Fellowship nominations, the highest award within the Royal College of GPs. I am a commentator for the Royal College of GPs on professional regulatory and medico-legal issues.

With reference to this case, I have postgraduate training in Gastroenterology and as a practicing GP I regularly have to investigate iron deficiency, refer for suspected bowel cancer and diagnose such.

Qualifications:
- **MBChB**, Bachelor of Medicine and Bachelor of Surgery, Edinburgh, 1998
- Advanced 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.
- **PGCert**, Postgraduate Certificate in Diabetes Care; Warwick, 2010

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

Full GP records.

Letter of Instruction dated 12th October 2011.

Record of attendance notes between Solicitor and Claimant

Appendix 3

Glossary of terms used

none

Appendix 4

Sources of references to published works

1. Procrastination and prognosis; medico-legal aspects of the diagnosis and timely treatment of colorectal cancer by Miss Carolynne Vaizey and Professor Robin Phillips. *Clinical Risk* 2006 volume 12 211-217. To quote from page 216; ' *This is to say, by the time a liver metastasis is detectable, it has been in the liver for more than three years and the patient has, to all extents and purposes, been incurable for that length of time*.'

2. Risk of Developing Colorectal Cancer Following a Negative Colonoscopy Examination, Evidence for a 10-Year Interval Between Colonoscopies. JAMA, May 24/31, 2006—Vol 295, No. 20 To quote from page 2372; *'In conclusion, our data are reassuring that the likelihood of developing Colorectal Cancer (CRC) after a negative colonoscopy result remains low for more than 10 years after the index procedure. The magnitude of the reduction in CRC incidence in the overall population after a negative colonoscopy result may not be as great as previously suspected. However, if a patient has a single negative colonoscopy result and does not require further colonoscopy for a particular clinical indication, the likelihood hood of developing CRC is extremely low and for this group a screening interval between colonoscopies can be reasonably set at more than 10 years.'*

3. Taken from Patient.co.uk; a common and widely used textbook medical resource;

'*Stool examination or description:*

Often possible on a home visit (is the motion still available to be seen?).

Blood mixed with stool: the blood is darker and this usually indicates a lesion on the left side of the colon or even transverse colon (often carcinoma or inflammatory bowel disease).

Shiny black- or plum-coloured stool is often not recognised by the patient as blood (melaena). This indicates bleeding from higher up the GI tract - these patients need admission for investigation (usually upper GI tract endoscopy), either immediately or through an upper GI tract bleeding fast-track service (see separate article Upper Gastrointestinal Bleeding).

Occult faecal blood loss may be severe enough to cause iron deficiency anaemia.

Bright red blood suggests a lesion in the rectum or anus. If blood is clearly separate from a stool it indicates an anal lesion, usually haemorrhoids or a fissure - particularly if there are associated anal symptoms (for example, anal pain or pruritus ani) but, occasionally, other pathology (for example, proctitis or anal carcinoma). This emphasises the need for rectal examination.

With blood on the surface of the stool the lesion can be anal, but may be a more proximal lesion (for example, polyp or carcinoma in the rectum or descending colon).'

4. Definition of IBS according to Dorlands Medical Dictionary; '*It is a functional bowel disorder characterized by chronic abdominal pain, discomfort, bloating, and alteration of bowel habits in the absence of any detectable organic cause'*.

5. Guidelines from the American College of Gastroenterology (ACG) January 2009 of *The American Journal of Gastroenterology*, the recommendations update the ACG's first statement, which was published in 2002. According to the 2009 recommendations, extensive testing (complete blood count, thyroid function test, stool testing for parasites, and abdominal imaging) is unnecessary for people with typical IBS symptoms who have no family history of colon cancer, inflammatory bowel disease, or coeliac sprue — and no "alarm symptoms," including rectal bleeding, weight loss, or iron-deficiency anemia.

6. Procrastination and prognosis; medico-legal aspects of the diagnosis and timely treatment of colorectal cancer by Miss Carolynne Vaizey and Professor Robin Phillips. *Clinical Risk* 2006 volume 12 211-217. To quote from page 212; '*Blood may be seen on the toiler paper, in the toilet, on the stool or mixed in with the stool. Only blood mixed in with the stool has been shown to be of predictive value identifying patients at higher risk of colorectal cancer*.'

7. Risk of Developing Colorectal Cancer Following a Negative Colonoscopy Examination, Evidence for a 10-Year Interval Between Colonoscopies. JAMA, May 24/31, 2006—Vol 295, No. 20.

8. Referral guidelines for Suspected Cancer; London Department of Health 2000.

9. The UK's Food Standards Agency (FSA) looked at sources of iron in their 2003 National Diet and Nutrition Survey and found that 17 per cent of total (haem and non-haem) iron came from meat, three per cent from fish, three from eggs and one per cent from dairy foods. The vast majority (over 75 per cent) of iron in the diet came from plant-based foods. Cereals (such as wholegrain pasta, brown rice and wholemeal bread) made the single biggest contribution at 44 per cent.

END OF REPORT