

# Notes – from HDC opinion 2009-2010

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- 10 June 2009: patient concerned about rash on his legs. Provisional diagnosis discoid eczema.
- 15 June 2009-November 2009: several consultations regarding management of eczema.
- 17 November 2009: Notes state *“itchy rash, relieved by prednisone but has recurred. Plan: refer to dermatologist Dr E.”*
- 19 November 2009: Dr E wrote to Dr B *“Very unpleasant widespread discoid eczema. Treatment recommended.”*
- 2 March 2010: Mr A referred to dermatologist Dr F for a second opinion for the continuing skin problem.
- 4 March 2010: Dr F writes *“Six month history of nummula eczema. Advice regarding management added.”* Additionally, Dr F notes a sternal lesion advising that it should be removed ? melanoma.
- 29 March 2010: Dr G from the same practice, lesion removed, histologically a superficial spreading melanoma.
- 24 June 2010: Dr B is requested by Mr A for a lab form after a homeopathy consultation regarding a skin condition, form giving, bloods tested that day.
- 29 June 2010: Practice requests Mr A to see Dr B to review blood results. Blood test results were normal except for the protein electrophoresis test which indicated monoclonal gammopathy. Histopathologist Dr H in that report wrote:  
*“Initial review and regular surveillance (six monthly, then 12 monthly if stable) should include clinical review, blood count, immunoglobulin qualification, protein electrophoresis, renal function and calcium. If there is a suspicion of myeloma or lymphoma referral to a clinical haematologist is recommended. Suggest a urine sample for the presence of monoclonal free light chains (Bence Jones protein).”*
- 30 June 2010: clinical notes read:  
*“Discussion re monoclonal antibody. Plan blood review end of August (prior to departure (overseas)).”*
- 12 August 2010: Mr A underwent the first of the follow-up tests as per the lab forms supplied on 30 June 2010. Included full blood count, urine test plus Bence Jones protein.
- 12 August 2010: Results received. All results normal but the Bence Jones protein test was positive.



- 12 August 2010: Dr B's clinical notes record: *"IBX: Bence Jones confirmation (note, abnormal)."*
- 30 August 2010 (week before overseas trip): Consultation notes read:  
  
*"Have decided homeopathy ineffective, worried about eczema while on holiday, would like to try prednisone, has had relapse of long-standing lower back pain following a coughing bout, had the flu about six weeks ago, cough persists.*  
  
*Heart sounds dual, no murmurs, chest clear.*  
  
*Plan: prednisone commencing with 30 mg tabs then 5 mgs as per Rx. Repeat regular medications, using codalgin for back pain PRN."*
- 16 October 2010: Dr B receives an email from Mrs A, informing him that Mr A is still having back issues and informing him that their travel insurance company would be contacting him. Dr B replied that he would reply and provide whatever information the insurance company needed, and expressed his concern for Mr A's back.
- 18 October 2010: Dr B completed a questionnaire for the insurance claim and returned it by fax.
- 24 October 2010: On return to New Zealand, Mr A was admitted to hospital for diagnosis of four collapsed vertebral bodies secondary to multiple myeloma, treatment being commenced.
- 1 November 2010: A significant event form noting an error had occurred, namely inadvertent filing of Mr A's abnormal result, was completed.
- 20 December 2010: HDC complaint made. Dr B responds to HDC.

