Avoiding urological litigation in general practice

JOHN M. REYNARD AND MARK E. SULLIVAN

The authors provide some tips on how GPs can avoid litigation by being aware of the urological symptoms and situations that should alert them to the possibility of serious pathology.

For claimants and defendants alike, the process which governs the judicial determination of allegations of negligent medical treatment is complex, time-consuming and often traumatic. The Hon. Mrs Justice Cox, Queen’s Bench Division¹

Many doctors find clinical negligence litigation a traumatic experience, so it makes sense to avoid it; its avoidance also means that a patient has not suffered harm, so it is a win–win situation. Of course, a balance must be struck between the overly defensive approach to diagnosis and the horizontally relaxed. As in hospital practice, expensive or invasive tests are not necessarily required for us to become better diagnosticians.

Our experience as expert witnesses has led us to conclude that much litigation in hospital and in general practice (where we are often asked by lawyers to comment) could be avoided by an awareness of certain symptoms or signs that can guide detection of serious pathology in amongst the ocean of benign, self-limiting pathology that is a feature of presentation in general practice.

What follows is simple advice to avoid pitfalls of diagnosis in general practice.

LOWER URINARY TRACT SYMPTOMS

As hospital specialists we imagine that GPs see a fair number of patients with lower urinary tract symptoms (LUTS). Most will have benign prostatic enlargement causing bladder outflow obstruction or an overactive bladder (OAB). Rarely, the man or woman in front of you will have one of the rare but serious causes of LUTS. The skill in diagnosis is in recognising, usually through a few simple questions, these rare causes in the ocean of benign prostatic hyperplasia (BPH) and OAB.

So, what symptoms and situations should alert you to the possibility of serious pathology?

Carcinoma in situ of the bladder

While the lifelong heavy smoker and employee of the local rubber and aniline dye factory with urgency and bladder pain

Figure 1. Cauda equina syndrome is a neurosurgical emergency: delayed diagnosis may lead to litigation. (© Scott Camazine/Science Photo Library)
and no haematuria probably does just have an OAB, a referral to the urologist for a cystoscopy will identify the ticking time bomb of carcinoma in situ of the bladder, which has the propensity for early invasion and metastasis. Urine cytology is often positive for cancer cells, but the definitive test is a cystoscopy.

**Chronic urinary retention**
Recent-onset bedwetting in an elderly man is almost pathognomonic for high-pressure chronic retention. On examination, the patient’s bladder will often be visibly distended and grossly so and easily percussable and palpable as a mass extending even above the umbilicus. The patient will very likely have a degree of renal failure. Same-day hospital admission is the safest course so that metabolic disturbances can be corrected and the sometimes profound hypotension that can follow catheterisation can be managed with intravenous fluids.

**Cauda equina syndrome**
In our experience GPs are often dragged into the litigation that follows alleged delays in diagnosing cauda equina syndrome (CES) and the resulting permanent loss of bladder, bowel and sexual function (Figure 1). Beware the patient with worsening back pain (often – though not always – with sciatica) with LUTS. Specifically ask about (and record the answers to) the presence of the following: perianal, vulval or penile tingling or numbness, altered urethral sensation (’I can’t feel myself weeing’), loss of a desire to void (waking from a night’s sleep and not feeling the usual desire to pass urine), hesitancy, poor urinary flow and needing to strain to void, loss of the ability to sense bladder fullness and a feeling of retention or incomplete voiding.

Any such symptoms in a patient with worsening back pain are red flags for CES. Anal tone may be preserved until late in the day, and incontinence (the loss of sphincter function) is a late symptom, so its absence does not exclude the diagnosis (and it is not enough therefore to say ’sphincters intact’ instead of ’no CES’ because they often are intact early in the evolution of a CES).

There is no time for complacency. When you make the emergency referral, speak to the most senior person available (the on-call orthopaedic or neurosurgery registrar). Be specific in both your written and spoken words – ’I am worried this patient has a cauda equina syndrome’ is an explicit statement of concern that cannot be misinterpreted (by the receiving doctor or by the courts). Try to avoid being fobbed off by the orthopaedic registrar who suggests you send the patient to casualty to be assessed by the (often very junior) doctors there. That is a way of delaying (and even failing to make) the diagnosis. The delays that sometimes occur with ambulance transfers may be avoided if a relative or friend can drive the patient to hospital. It is not unknown for an ambulance crew to decide, incorrectly, that there is no CES! In our experience ambulance trusts not infrequently become defendants in such cases.

Such cases very often settle in favour of the claimant, and to avoid subjecting patients to a life of loss of pelvic and perineal function and to save yourself the heartache of litigation, an awareness of how CES presents and that it is a genuine neurological emergency is critical.

**Floppy iris syndrome**
Floppy iris syndrome is a potential side-effect of alpha-adrenergic blockers, which may occur during cataract surgery in men taking these drugs for ‘BPH-LUTS’. The syndrome is characterised by miosis, billowing of the flaccid iris and iris prolapse through the incision. The mechanism may relate to inhibition of iris dilution by alpha-blockade. The risk of floppy iris syndrome is substantial with tamsulosin (43–90 per cent). The American Urological Association BPH guidelines recommend that alpha-blockers should be avoided in patients with planned cataract surgery until this has been completed. As GPs often prescribe alpha-blockers, it is as well to be aware of this advice.

**VASECTOMY**
Although urologists only rarely do vasectomies, we are very aware that it is a medico-legal minefield for the unwary. The issue is primarily one of consent; one should be mindful of the British Association of Urological Surgeons procedure-specific consent form for vasectomy, which outlines the risk of complications in detail (Box 1). You may not agree with the content, but it is difficult to criticise a doctor who uses it, as it is a standard of consent endorsed by a responsible body of opinion. In particular, we would draw attention to the occurrence of chronic testicular pain in 10–30 per cent, which in a small proportion can be disabling and impact on the ability to work.

**RECURRENT URINARY TRACT INFECTIONS**
From time to time, a patient with recurrent urinary tract infections (UTIs; more than two infections in six months or more than three in 12 months) may have an underlying and otherwise completely asymptomatic (pain-free) staghorn renal calculus, which acts as a focus of infection. A plain abdominal x-ray is easily done, minimally invasive and diagnostic.

Before resorting to low-dose antibiotics in such cases, avoid the criticism that you have failed to use simple and safe measures in the women plagued by UTIs. Maximise fluid intake (3 litres plus daily), suggest cranberry juice or tablets and avoidance of spermicidal contraceptives, and offer self-medication with short courses of antibiotics or a single dose of an antibiotic before or shortly after intercourse, and suggest application of natural yoghurt to the vagina to colonise it with ‘good’ bacteria. Topical or systemic oestrogens help after the menopause by re-acidifying the vagina.
A small amount of bruising and scrotal swelling is inevitable for several days. Early failure of the procedure to produce sterility (1 in 250–500). Inflammation or infection of the testes or epididymis requiring antibiotic treatment. Blood in the semen for the first few ejaculations. Seepage of a small amount of yellowish fluid from the incision several days later. The procedure should be regarded as irreversible. Although vasectomy may be reversed, this is not always effective in restoring fertility, especially if more than seven years have lapsed since the vasectomy. Sufficient specimens of semen must be produced after the operation until they have been shown to contain no motile sperms on two consecutive specimens. Contraception must be continued until no motile sperms are present in two consecutive semen samples. Chronic testicular pain or sperm granuloma (tender nodule at the site of surgery). Significant bleeding or bruising requiring further surgery. Re-joining of vas ends, after negative sperm counts, resulting in fertility and pregnancy at a later stage (1 in 4000).

### COMMON (GREATER THAN 1 IN 10)
- A small amount of bruising and scrotal swelling is inevitable for several days
- Seepage of a small amount of yellowish fluid from the incision several days later
- Blood in the semen for the first few ejaculations
- The procedure should be regarded as irreversible. Although vasectomy may be reversed, this is not always effective in restoring fertility, especially if more than seven years have lapsed since the vasectomy
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- Contraception must be continued until no motile sperms are present in two consecutive semen samples
- Chronic testicular pain or sperm granuloma (tender nodule at the site of surgery)

### OCCASIONAL (BETWEEN 1 IN 10 AND 1 IN 50)
- Significant bleeding or bruising requiring further surgery
- Inflammation or infection of the testes or epididymis requiring antibiotic treatment

### RARE (LESS THAN 1 IN 50)
- Early failure of the procedure to produce sterility (1 in 250–500)
- Re-joining of vas ends, after negative sperm counts, resulting in fertility and pregnancy at a later stage (1 in 4000)

Where simple advice has failed, a regimen of so-called ‘rotating’ low-dose bed-time antibiotics can be effective – two months each of nitrofurantoin 100mg, trimethoprim 100mg and cephalaxin 250mg. Side-effects are rare, but they do occur and can be serious, permanent and life-transforming. In the era of patient autonomy it would be difficult to defend a failure to advise of these risks – it is for the patients to balance the risks, which of course they can do only if given the information by you. Severe pulmonary fibrosis (manifesting as breathlessness), aplastic anaemia and peripheral neuropathies may follow even low-dose nitrogen mustard. Rare side-effects of trimethoprim include depression of haematopoiesis, erythema multiforme, toxic epidermal necrolysis and photosensitivity.

**Testicular Torsion**
A failure to diagnose this surgical emergency is a frequent source of requests from claimant lawyers and defence organisations for an expert urological opinion. The defendant – often a GP – is alleged to have failed to recognise the symptoms and signs and therefore to have missed the diagnosis. This is primarily a clinical diagnosis, based on the correct interpretation of the presence of sudden onset of testicular pain. It may follow minor trauma (a red herring). Previous episodes lasting minutes or a few hours may indicate spontaneous detorsion. A slight fever may be present.

Occasionally there may be no reported testis pain, but rather pain referred to the groin (incorrectly diagnosed as groin strain) or loin (reflecting the embryological origin of the testis and its nerve supply from T10/11). A simple examination of the testes is all that is required.

The testis is usually very tender even to light touch and it may be impossible to perform even gentle palpation between the fingers and thumb – this indicates the likelihood of a torsion. It is usually possible with gentle examination to distinguish tenderness in the body of the testis from that isolated to the epididymis (epididymitis), which sits on top of the testis.

More subtle signs of a high-riding, horizontally lying testis or loss of the cremasteric reflex lack reliability – the key features are testis pain and tenderness.

Urgent referral for early surgical exploration gives a greater chance of being able to salvage the torted testicle. The best chance of salvaging the testis is with detorsion within four hours of the onset of pain (100 per cent salvage rate), with 90 per cent being saved by detorsion within six to eight hours.

**Haematuria**
Blood in the urine is now described as visible haematuria (VH) or non-visible haematuria (NVH), the former always being symptomatic (if only by its presence) and the latter being symptomatic or asymptomatic. Urine dipstick of a fresh voided urine sample, containing no preservative, is considered a sensitive means of detecting the presence of NVH. Routine microscopy for confirmation of NVH is not necessary.

Trace haematuria should be considered negative, while 1+ or greater is significant. There is no distinction in significance between haemolysed and non-haemolysed haematuria.

Urinary tract infections, exercise-induced haematuria and menstruation cause transient haematuria. Re-test when the UTI has been treated, menstruation has finished and after a period of ‘abstinence’ from exercise. VH or NVH should not be attributed to anticoagulant or antiplatelet therapy prior to investigation.

Failure to refer to a urologist is a frequent cause of urological litigation for GPs (Box 2). It is likely that most (if not all) patients with a renal cancer initially have a degree...
of NVH before they progress to a state of VH, and earlier diagnosis is undoubtedly associated with lower stage and a higher chance of cure. By the time a patient has developed VH, for many a cancer of cure has been lost, so one could argue that as much attention should be directed at cases of NVH as VH.

PSA AND PROSTATE CANCER
Again, a failure to diagnose prostate cancer when at an early, potentially curable stage is a not infrequent source of criticism of GPs.

Lower urinary tract symptoms do not allow one to distinguish between prostate cancer and benign enlargement of the prostate, so if a man is a candidate for prostate cancer treatment and wishes to know whether or not he has prostate cancer, a digital rectal examination (DRE) and PSA should be done after counselling with regard to the implications.

Consider the possibility of prostate cancer not only in men with LUTS, but also in those with erectile dysfunction, haematuria, lower back pain, bone pain or weight loss. Urgent referral is required:
1. If a hard, irregular prostate typical of a prostate carcinoma is felt on DRE
2. In a patient with or without LUTS in whom the prostate is normal on DRE but the age-specific PSA is raised or rising
3. If there is doubt about whether to refer an asymptomatic man with a borderline level of PSA, repeat the PSA after one to three months
4. If the second test indicates that the PSA level is rising, the patient should be referred urgently.

FINALLY...
It is becoming increasingly difficult to base a defence on poor or sparse documentation of what was said and found during a consultation and examination. Judges can become irritated when, through a lack of accurate documentation, you must rely on ‘what I would have done’ – they want to know what you actually did, and there is no substitute; nothing will provide a substitute to carefully written notes.

REFERENCES