



KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 24: Abnormal Pap Smear / HPV Test Lost to Follow-Up – Who Is Responsible When Cervical Cancer Is Diagnosed Later?

1. REAL LIFE CASE SCENARIO

A 42-year-old woman underwent routine cervical cancer screening. Her report showed a significant abnormality requiring further evaluation with colposcopy and possible biopsy. The report reached the hospital, but there was no documented communication with the patient and no tracking system for abnormal results. The woman did not return. Eighteen months later, she presented with postcoital bleeding and was diagnosed with invasive cervical cancer. The family alleged that the earlier abnormal report had never been communicated and that timely treatment could have prevented progression. The crucial medicolegal question became: Is ordering a test enough — or does the doctor's responsibility extend to reviewing, communicating, and acting upon an abnormal result? The investigation may have been performed correctly. The failure may occur after the report is generated.

2. MEDICOLEGAL RISKS IN SUCH CASES

Modern gynecological practice generates numerous reports requiring follow-up:

- Pap smear / HPV testing
- Cervical and endometrial biopsy
- Histopathology reports
- Tumor markers
- Ultrasound and mammography
- STI investigations

Common allegations: failure to review an abnormal report, failure to inform the patient, no recall system, no documentation of communication, failure to refer, assuming the patient would return automatically.

3. WHAT THE LAW EXPECTS

A doctor is expected to exercise reasonable care throughout the diagnostic process, including appropriate systems for:

- Reviewing important investigation results
- Recognizing clinically significant abnormalities
- Communicating relevant results to the patient
- Advising appropriate further evaluation
- Documenting recommendations clearly
- Facilitating timely referral when required

There is a major medicolegal difference between “The patient was never informed” and “The patient was informed, advised colposcopy, but did not return despite counseling.”

Documentation establishes that difference.

4. DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

- | | |
|---|--------------------------------------|
| • Date the report was received. | Exact abnormality noted |
| • Date patient was informed. | Method of communication used |
| • Further evaluation advised. | Colposcopy / biopsy recommendation |
| • Urgency explained to patient. | Follow-up appointment given |
| • Referral details where applicable. | Patient refusal / non-attendance |
| • Repeated contact attempts documented. | Written follow-up instructions given |

Example entry: “Abnormal cervical screening result discussed with patient. Need for colposcopy and directed biopsy explained.

Importance of timely evaluation and risk of significant cervical pathology discussed. Review advised within ___ weeks.”



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5. PRACTICAL SAFE PRACTICE – WHAT TO DO

- Never depend solely on the patient returning voluntarily
- Create an abnormal-result tracking system
- Identify and prioritize high-priority reports
- Maintain updated patient contact details
- Communicate significant abnormalities promptly
- Give written follow-up instructions
- Maintain a recall register or electronic alert system
- Document unsuccessful contact attempts
- Refer appropriately when specialist care is required

Even a simple register for abnormal Pap/biopsy reports can prevent dangerous loss to follow-up in resource-limited settings.

6. COMMON MISTAKES TO AVOID

- Filing abnormal reports without review
 - Assuming “the laboratory will inform her”
 - Giving only verbal follow-up advice
 - No documentation of telephone communication
 - No tracking of abnormal histopathology
 - Repeatedly postponing colposcopy
 - Failure to act on persistent HPV positivity
 - Blaming the patient without evidence that follow-up was advised
- A report sitting inside a file does not protect the patient.

7. CLINICAL–LEGAL PEARL

Ordering the investigation is only half the job.

Order → Receive → Review → Communicate → Act → Document.

8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)

In delayed-diagnosis litigation, courts examine the entire chain of care. Important questions include:

- Who received the abnormal report?
- Was it reviewed by the treating doctor?
- Was the patient informed of the result?
- Was appropriate follow-up advised?
- Was the urgency communicated clearly?
- Did the patient subsequently fail to comply?

A doctor should not automatically be blamed when a properly informed patient chooses not to return. But without documentation of communication, proving that counseling occurred months or years later becomes very difficult.

9. TAKE-HOME MESSAGE

Cervical cancer screening saves lives only when abnormal results lead to appropriate action. Every practice should have a simple system ensuring that important abnormal reports do not disappear inside files. Do not merely order the test. Close the loop.

An unreviewed report protects nobody.

A communicated result protects the PATIENT and the DOCTOR.

Next Week's Topic; Birth Injury and Shoulder Dystocia – When Does an Unavoidable Obstetric Emergency Become a Negligence claim?



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