香港醫務委員會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Dates of hearing: 28 June 2012 (Day 1), 14 July 2012 (Day 2)

Defendant: Dr IP David (Reg. No. M06140)

1. The charge against the Defendant, Dr IP David, is that:-

> "On 23 October 2009 he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient") in that he prescribed mefenamic acid to the Patient when he knew or should have known that the Patient was allergic to aspirin.
>
> In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of the case

2. At the material time, the Patient consulted the Defendant presenting with symptoms of urinary tract infection, with mild painful urination. She informed the Defendant that she was allergic to aspirin. The Defendant assured her that he would prescribe medicines containing no aspirin. The Defendant then prescribed 4 medicines, including mefenamic acid.

3. The Patient took the medicines at 9:00 pm. At 2:30 am she woke up with pain and pruritus of the thigh. She developed urticaria rash over the left thigh and right armpit. She went to the Accident and Emergency Department of a public hospital at 3:23 am, and was diagnosed with allergy to mefenamic acid. She was treated with chlorpheniramine maleate and emulsifying ointment, and discharged at 4:44 am.

4. The painful rash lasted for about a week and darkened, and took about a month to subside completely.

Council's findings

5. Aspirin and mefenamic acid are both non-steroidal anti-inflammatory

drugs ("NSAIDs").

6. Allergic reactions to NSAIDs can be either true allergy or pseudo-allergy.

7. True allergy is idiosyncratic, i.e. peculiar to the individual person. True allergy to one NSAID only indicates allergy to structurally similar NSAIDs but not other NSAIDs with different molecular structures. Therefore, a patient truly allergic to an NSAID is a single reactor.

8. Pseudo-allergies are related to inhibition of the action of the enzyme cyclooxygenase-1. Pseudo-allergies may be triggered by aspirin and all cross-reacting NSAIDs, including mefenamic acid. A patient who is pseudo-allergic to NSAIDs is a cross-reactor, and is more likely to have underlying history of asthma, nasal polyps, chronic rhinosinusitis, or chronic urticaria. Pseudo-allergies are much more common than true allergies.

9. When a patient presents with a history of allergic reaction to aspirin, the potential exists that he/she may be a cross-reactor. It is unsafe to prescribe another NSAID unless it has been ascertained that the patient is not cross-reacting to that other NSAID. Where there are safer alternatives, there is no reason to take the risk of prescribing another NSAID, particularly if detailed history has not been taken to establish whether the patient has asthma, urticaria or other allergic reactions.

10. Proper prescription involves a risk-benefit analysis process. Given that cross-reaction among different NSAIDs is a known risk, if there is known allergy or pseudo-allergy to one NSAID, care must be taken to eliminate the possibility of allergy to another NSAID intended to be prescribed.

11. In the present case, the Defendant only knew that the Patient was allergic to aspirin. There was no evidence that he took adequate history to ascertain the presence or absence of risk factors, such as asthma, nasal polyps, chronic rhinosinusitis, or chronic urticaria. Failing to do so indicates that the Defendant had not conducted a proper risk-benefit analysis before prescribing mefenamic acid to the Patient. He did not inform the Patient of the possible allergic reaction. In the circumstances, either he was taking an unreasonable risk, or he was simply not aware of the possibility of cross-reaction between aspirin and mefenamic acid.

12. In the present case, there were safer alternatives such as paracetamol for the Patient's symptom of mild painful urination.

13. The Defendant's expert witness agrees that paracetamol rather than an NSAID would be the first choice for the Patient. He also agrees that there was no information for the Defendant to conclude whether the Patient was

truly allergic or pseudo-allergic to aspirin. He acknowledges that the Defendant should have avoided another NSAID because it could have caused more harm.

14. The Defence Solicitor argues that the Patient only said that she was allergic to aspirin without giving further relevant history, therefore the Defendant was entitled to conclude that it was a true allergy to aspirin. We disagree. Even if a patient has not volunteered any information, a doctor has the responsibility to ascertain from the patient the relevant history. It must be borne in mind that patients are not medically trained and would not know what information needs to be given. Furthermore, a doctor must be alert to the fact that most patients would not know the difference between true allergy and pseudo-allergy, and would simply use the layman term of allergy.

15. We are satisfied that the Defendant's conduct was below the standard expected amongst registered medical practitioners. We find him guilty of professional misconduct as charged.

Sentencing

16. The Defendant has a clear record.

17. The Patient suffered pain for a week and rash which took a month to subside. Although it was not a very serious allergic reaction, it cannot be characterized as mild reaction.

18. Drug allergy can be serious, in some cases fatal. We must also point out that allergic reactions are not dose dependent, and serious reactions can be triggered by small doses. It was fortunate that the Patient had not suffered more serious reactions.

19. The Defendant has taken steps to update his knowledge in drug prescription. Nevertheless, his approach to the inquiry shows that he still believes that there was no problem with his prescription, which in turn shows that he has not properly understood the problem.

20. Having regard to the gravity of the case and the mitigating factors, we order that his name be removed from the General Register for a period of 1 month, and that the order be suspended for a period of 12 months, subject to the condition that he completes within the suspension period course(s) of continuing medical education on safe use of drugs to the equivalent of 10 CME points. The CME course(s) should be approved by the Council in advance, and evidence of satisfactory compliance with the condition should be provided to the Council within 1 month after the

expiry of the suspension period.

Other remark

21. The Defendant's name is included in the Specialist Register under the specialty of Rehabilitation Medicine. We are of the view that the present case is relevant to his specialty. As it is the function of the Education and Accreditation Committee to consider whether to take any action in respect of his specialist registration, it will be more appropriate for us to leave it to the Committee to decide whether the case reflects adversely on his specialist competence.

Prof. Felice LIEH-MAK, GBS, CBE, JP
Temporary Chairman, Medical Council