SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Joseph Antonio Zadra (CPSO# 52584)
(the Respondent)

INTRODUCTION

The Patient's family physician referred him to the Respondent (Urulogy) for issues related to urinary flow. The Respondent performed a transurethral resection of the prostate (TURP) on the Patient. The Respondent followed the Patient for several years, and then saw him again on re-referral.

The Patient's family physician was concerned about the Patient's elevated prostate-specific antigen (PSA) tests and referred him to another urologist who performed a biopsy, which showed the Patient had prostate cancer.

A family member of the Patient contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **failed to properly assess and diagnose why the Patient's PSA levels were increasing after his initial TURP in 2013;**
- **told the Patient that his elevated PSA levels were no cause for concern even though he was subsequently diagnosed with prostate cancer with metastases; and**
- **failed to follow up a failed ultrasound biopsy attempt in 2018 even though a subsequent MRI indicated a high suspicion of cancer.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of April 17, 2020. The Committee decided to require the Respondent to attend at the College to be cautioned in person with respect to follow-up testing and the management of PSA and residual prostate after TURP. The Committee also negotiated an undertaking with the Respondent focused on improving his clinical care, including clinical supervision, professional education and reassessment following completion of the clinical supervision.

COMMITTEE'S ANALYSIS

Concern that the Respondent failed to properly assess and diagnose why the Patient's PSA levels were increasing after his initial TURP in 2013

Concern that the Respondent failed to follow up a failed ultrasound biopsy attempt in 2018 even though a subsequent MRI indicated a high suspicion of cancer

Given the Respondent was following the Patient post-TURP (where all the prostate had not been removed), he should have routinely performed prostate examinations on the Patient. As it was, the Respondent did not document prostate examinations or any PSA levels in his lengthy follow-up of the Patient after the TURP.

The Patient's family physician later referred him back to the Respondent; it was the finding on digital examination, which the family physician performed, that triggered the ordering of a PSA test that showed elevated PSA levels.

The Respondent was inappropriately comforted by a subsequent MRI report, believing that it showed normal prostate tissue. In fact, the MRI report suggested another attempt at biopsy.

Overall, this clinical picture should have led the Respondent to make further attempts to definitively rule out prostate cancer.

The Respondent's College history includes a previous caution in person for failing to follow recommendations for further investigation resulting from a test which he had ordered; this present case was clearly similar.

The Committee therefore required the Respondent to attend at the College to be cautioned, and accepted an undertaking from the Respondent, as set out above.

The Committee took no further action on the concern respecting the Respondent's statements to the Patient about his elevated PSA levels.