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. Oshiomeghe Kenneth Ogah (CPSO #108300)
(the Respondent)

INTRODUCTION

The Patient contacted the College with concerns about the care she received from the Respondent.

The Patient, who was in her early twenties, attended the Emergency Department with severe lower abdominal and pelvic pain. An ultrasound was ordered and showed a complex adnexal and ovarian mass; the radiologist noted the findings could relate to bilateral endometrioma or complex cystic ovarian masses with some suspicious features. The Respondent was consulted and performed a surgical procedure.

Over the next few months, the Respondent saw the Patient for follow up on four occasions before discharging her back to her family physician. A few weeks later, the family physician re-referred the Patient to the Respondent, with an updated ultrasound showing re-accumulating cysts. The Respondent then saw the Patient another three times and eventually referred her to a gynecologic oncologist.

The gynecologic oncologist carried out a laparoscopy with biopsies, omentectomy and pelvic washings on the Patient and the pathology specimens indicated a low-grade serous ovarian carcinomatosis.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of May 16, 2025.

The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to:

- appropriate investigations and management of complex ovarian cysts, including differential diagnosis, surgical management and referrals to a gynecologic oncologist;
- follow-up on tests, including ultrasound, to monitor patients with complex ovarian masses and endometriosis;
- the importance of accurately informing patients of the details of surgery; and
- accuracy of medical records documentation.

The Committee also accepted the Respondent’s undertaking in this matter.

COMMITTEE’S ANALYSIS

The information before the Committee strongly suggested that the procedure the Respondent performed was ovarian cystotomies and not ovarian cystectomies, as he stated in his College response. The Committee was troubled that the Respondent did not inform the Patient of the change from the originally proposed surgery.

The Respondent gave a verbal order for the Patient to have a CA125 test, but that test was never done. The Committee was concerned that the Respondent did not follow up to ensure that the test had been performed and a result had been reviewed.

The Respondent appeared convinced that the Patient had ovarian endometriosis, even though the ultrasound had features that are often associated with ovarian neoplasm. The Committee was puzzled as to the Respondent’s reasoning for not attempting to remove the cyst capsule at surgery even if he thought he was dealing with an endometrioma. If the capsule was very adherent, as can be the case with an endometrioma, then given the size of the cyst at least a resection of part of the cyst wall could have been performed. Given that pus-like material drained from the cysts, the Respondent should have sent this material for cytology and culture. If none of these actions were considered, the minimum should have been that peritoneal washings for cytology were obtained.

The Respondent acknowledged that no specimen was sent for histological or cytological analysis. He stated that he relied on the pelvic ultrasound report, his observation during surgery suggesting benign appearance, the Patient’s age and the rarity of this type of carcinoma in her age group. The Committee noted that an ovarian surgical specimen, regardless of whether the surgeon suspects it to be benign or malignant, must be sent for examination by a pathologist. Given the ultrasound findings as well as the size of the mass at surgery, in the Committee’s view, this constituted a significant lapse in the Respondent’s judgement.

Regarding the post-operative care, even if the Respondent believed that the Patient was well enough to be discharged back to her family physician, the content of the ultrasound that was attached to the re-referral should have prompted him to make an immediate referral to a gynecological oncologist or at least have an urgent consultation with the Patient. Instead, the Respondent only saw the Patient almost seven weeks later.

It was very troubling for the Committee that, overall, it took the Respondent approximately eight months from his first encounter with the Patient to acknowledge the malignancy suspicion in this case and consider a referral to a gynecologic oncologist.

Therefore, the Committee required the Respondent to appear before a Panel of the Committee to be cautioned as outlined above.

This is a summary of the Committee's decision as it relates to the caution disposition.