## **SPSO decision report**



| Case:    | 201104981, A Medical Practice in the Greater Glasgow and Clyde NHS Board area |
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| Sector:  | health  |
| Subject: | clinical treatment; diagnosis   |
| Outcome: | not upheld, no recommendations  |

## Summary

Mrs C was diagnosed with advanced bowel cancer in January 2011. She told us that from March 2010 the practice had failed to properly investigate the symptoms she was presenting with, and that she should have been referred to hospital earlier.

We did not uphold Mrs C's complaints. We found that the practice's care had been good. Our medical adviser said that, although with hindsight it could be suggested that a significant pattern was emerging, this was not evident at the time. From March until September 2010 Mrs C had presented with a variety of non-specific symptoms including exhaustion, abdominal pain, bloating and vomiting. She had been prescribed HRT (hormone replacement therapy) which had helped with some of her symptoms. However, her abdominal pain continued, and Mrs C was referred for an ultrasound scan. She also attended a hospital accident and emergency unit a couple of days before the scan appointment due to a bout of severe pain. The ultrasound scan results did not prompt further investigation, and Mrs C did not return to the practice until November 2010. At this stage she was displaying trigger symptoms for bowel cancer including weight loss and a change in bowel habit, and was urgently referred for a colonoscopy (examination of the bowel with a camera on a flexible tube) following the results of blood tests.

Although the practice could have arranged for Mrs C to undergo blood tests earlier, we did not find that their care of her had been deficient. We noted that they had carried out a significant event analysis of what had happened, and had identified some learning points for the future.

Mrs C also complained she should have been sent for an earlier colonoscopy, rather than the ultrasound scan. We found, however, that sending her for the ultrasound scan was appropriate, given the symptoms Mrs C was displaying at the time. We also found that the practice acted reasonably after receiving the scan results, although we noted that they missed an opportunity to review Mrs C in person at that stage, and drew this to their attention.