SPSO decision report

Case: **201201491, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C's son (Mr A) attended a hospital accident and emergency department (A&E) complaining of left-hand rib pain, and pain in his elbows, right hip and shoulder, left wrist and lower back. An A&E junior doctor arranged for him to have a chest x-ray and reported that there was evidence of a lytic lesion (an area of bone damage, which can be caused by cancer) on one of Mr A's ribs. The doctor made an urgent referral for Mr A to be seen at the chest clinic. The x-ray was later reviewed and formally reported by a senior trainee radiologist. They did not identify a lytic lesion and did not mention it on the formal x-ray report. Based on the x-ray report, the consultant respiratory surgeon at the chest clinic contacted Mr A's GP and advised that there was nothing to be concerned about. He arranged for repeat x-rays in six weeks and did not see Mr A in his clinic. Mr A's condition deteriorated and he was ultimately diagnosed with advanced cancer, probably gastric in origin, which had spread to his bones. Mr C complained that radiology staff provided conflicting interpretations of the x-rays, causing a delay to Mr A's diagnosis.

After taking independent advice from two medical advisers, our investigation found that the lesion was present on the original x-ray but was not reported by the senior trainee radiologist. We acknowledged that the lesion was not clear and that it was not necessarily unreasonable that the radiologist did not identify it at that time. However, clearer abnormalities were missed by radiology staff on further x-rays taken the following month. We were also concerned that the consultant made a definitive decision about Mr A's condition based only on the x-ray report, when there was evidence that he had seen the A&E doctor's conclusions and had possibly reviewed the x-ray films himself. We considered that, based on the information available to him, the consultant should have seen Mr A in his clinic. We found that Mr A's diagnosis was delayed as a result of this. Although we recognised that this would not have affected his prognosis, he could have entered palliative care sooner and his pain could have been managed more effectively.

Recommendations

We recommended that the board:

- apologise to Mr C and his family for the failings that led to the delay to diagnosing Mr A's cancer;
- ask their radiology and respiratory staff to reflect on this case with a view to identifying points of learning for the future; and
- conduct a serious incident review of Mr A's case.