S.31/02-03

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman of an investigation into a complaint against South Glasgow University Hospitals NHS Trust

Complaint as put to the Ombudsman

1. The background to the complaint provided by Mr S was that on 13 February 1998 his wife, Mrs S, who was suffering from lower abdominal pain, was referred by her general practitioner (GP) to the Victoria Infirmary (the Infirmary). On 31 March 1998 she was seen there at a consultant surgeon's clinic (the First Consultant Surgeon). A rigid sigmoidoscopy revealed no abnormality. A barium enema and pelvic ultrasound were arranged. The barium enema took place on 2 July. The barium enema and pelvic ultrasound were negative. On 25 August she was reviewed by the First Consultant Surgeon and discharged with a diagnosis of irritable bowel syndrome.

2. On 15 September 1998 Mrs S was referred by her GP to the Infirmary again because she had developed anaemia and the pain was persisting. On 29 September she was seen at the First Consultant Surgeon's clinic. As a result she was admitted to the Infirmary in October for further investigation. In December she was referred to another surgeon for colonoscopy which was performed on 28 January 1999 when a tumour was found. Mrs S received adjuvant chemotherapy but relapsed. She died on 22 March 2001.

3. The matter subject to investigation was that between March 1998 and January 1999 the Trust took an unreasonable length of time to diagnose Mrs S's bowel cancer.

Investigation

4. The statement of complaint for the investigation was issued on 23 August 2002. Comments were received from the Trust and relevant papers including Mrs S's medical records were examined. Two independent professional assessors, a Consultant in General Surgery (the First Assessor) and a Consultant Radiologist (the Second Assessor), were appointed to advise on the clinical issues in this report. Their reports are reproduced in full at paragraphs 15 and 16. I have not included in my report every detail investigated but I am satisfied that no matter of significance has been overlooked. The medical terms used in the report are explained in the attached appendix.

Evidence of Mr S and Mrs S's daughter

5. In correspondence with the Trust during the Trust's investigation of the complaint, **Mr S and Mrs S's daughter** wrote:

> In a letter dated 25 April 2001
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> '... Our mother first attended [the Infirmary] in 1998 under [the First Consultant Surgeon] for bowel problems. [The First Consultant Surgeon] carried out various tests over the year but could not find anything wrong. My mother was losing blood with bowel movements, I understand this is a sign of cancer, yet [the First Consultant Surgeon] continued to say there was nothing wrong and that she was a mystery.
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> 'In January 1999 [the First Consultant Surgeon] passed my mother's case to another more experienced doctor who carried out one test and found a tumour. In February 1999 my mother went through an operation to remove the tumour and was then passed on to the Beatson Oncology Centre for further treatment. Unfortunately this was not successful and the cancer returned to my mother's lungs and stomach ...'.
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> In a letter dated 2 October 2001
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> '... In March 1998 ... [the First Consultant Surgeon] ... carried out tests and said [Mrs S] had irritable bowel syndrome while in fact we

know through further investigations that she had a 6mm in diameter colon carcinoma. It is unacceptable that this was missed.

'In September 1998 she was referred back to [the First Consultant Surgeon] by her GP … due to a low haemoglobin count. A haemoglobin of less than 50% in a woman who has had a hysterectomy should be regarded as a red alert.

'The above scenario calls for urgent gastrointestinal investigation including barium meal and follow through, MRI scans, barium enema and colonoscopy.

'… the presumptive diagnosis … is malignancy … My mother had to request a second opinion in December 1998. She was referred to [another consultant surgeon – the Second Consultant Surgeon] who discovered a tumour …

'For any person to be left in excruciating pain for a full year is totally unacceptable …'.

6. Mr S and Ms J told the Ombudsman's Investigator that in February 1998 Mrs S was referred to the First Consultant Surgeon, by her GP, with severe stomach pain. After a number of tests, Mr S accompanied his wife to the clinic for a follow up appointment (25 August) when the First Consultant Surgeon told them that the tests had shown that there was nothing there and said that Mrs S was a mystery. The First Consultant Surgeon discharged her. Mrs S was referred back to the First Consultant Surgeon in September because she had a low blood count, there was blood in her bowel movements and she was still in a lot of pain. At the appointment they also told the First Consultant Surgeon that Mrs S was losing weight but all she said about that was that Mrs S could do with it. Mr S said that the weight had been falling off his wife. Mrs S was admitted to the Infirmary for further investigation on 5 October. At the follow-up appointment the First Consultant Surgeon was going to discharge Mrs S and said she would have to learn to live with the pain. They told her that they were not happy with that and that they wanted a

second opinion. The First Consultant Surgeon agreed and referred Mrs S to the Second Consultant Surgeon (9 December). When Mrs S saw the Second Consultant Surgeon she pointed to the site of the pain and he found the tumour after one test.

7. Mr S and Ms J felt that the First Consultant Surgeon cannot have undertaken the correct tests and that she should have referred Mrs S to the Second Consultant Surgeon earlier. Their main concern was the complete lack of urgency shown by the First Consultant. As a result of the failure to diagnose Mrs S's condition she lost her appetite and suffered excruciating stomach pain for over a year.

Evidence of the Trust

8. During the Trust's investigation of the complaint the Trust's **Chief Executive** wrote:

> '[The First Consultant Surgeon] confirmed that your mother first presented in March 1998 with lower abdominal pain. A rigid sigmoidoscopy, pelvic ultrasound and barium enema were carried out and all were reported as normal. Symptoms were consistent with irritable bowel syndrome and as all investigations were normal, it was not thought necessary to pursue the issue further and your mother was discharged from the clinic in August 1998.
>
> 'Your mother's General Practitioner … re-referred her in September 1998 with ongoing abdominal pain and fatigue and at this point she was found to be anaemic with evidence of occult blood in her faeces. [The First Consultant Surgeon] advised that she was concerned about your mother by this time and arranged for her admission as an emergency for investigations. Your mother was therefore admitted in October 1998 and gastroscopy, pelvic ultrasound and flexible sigmoidoscopy were carried out. In view of the faecal blood, the intestinal tract was being investigated to look for a source of bleeding. A barium meal and follow through which was carried out was reported as normal. In December 1998 following the normal barium meal and follow through, and taking

into account the continuing anaemia, [the First Consultant Surgeon] referred your mother for a colonoscopy. This was carried out by [the Second Consultant Surgeon] in January 1999 and finally a diagnosis was made of a tumour in the ascending colon.

'[The First Consultant Surgeon] appreciates that the diagnosis was rather delayed but advised that unfortunately it is not always possible to make an immediate diagnosis in cases of bowel cancer and your mother's cancer was not seen on her initial x-rays. The barium enema x-ray has been reviewed with the Radiologists since your mother's diagnosis and they still are of the opinion that this does not show any definite abnormality.

'[The First Consultant Surgeon] noted your comment that she had said there was nothing wrong with your mother. However, [the First Consultant Surgeon] indicated that she was concerned and therefore arranged repeat investigations, and although she may have tried to reassure you while continuing these investigations, this did not imply that she was not concerned about your mother. ...'

9. In reply to the Ombudsman's statement of complaint the Trust's **Director of Nursing** replied that the Trust did not accept that the complaint was justified.

10. **The First Consultant Surgeon** said during the Ombudsman's investigation that in 1998/1999 the waiting time for barium enemas was about six months. When they saw Mrs S in clinic in 1998 she had been complaining of lower abdominal pain for the previous ten years. She had been investigated between 1989 and 1992 by another Consultant Surgeon and a Consultant Gynaecologist. All investigations had been normal including a barium enema undertaken in January 1989. By 1998 her clinical symptoms had not changed significantly from her original presentation in 1989. There were no abnormalities on clinical presentation. The working diagnosis at the time was of irritable bowel syndrome. There seemed therefore no indication to request an 'urgent' or

'soon' barium enema. Mrs S had a barium enema after three months which was quicker than normal. By 25 August 1998, in light of the investigations carried out and the normal results, she felt it reasonable to discharge Mrs S at that time.

11. The First Consultant said Mrs S was referred back to her by the GP on 15 September. She saw Mrs S on 29 September and was concerned about her condition. The only way to speed up investigations was to admit her to hospital and this was arranged for 5 October. At that time Mrs S had a raised ESR, anaemia and she was FOB positive. However, she had also had a recent report of a normal barium enema. The First Consultant Surgeon explained that the sigmoid colon is the area in which lesions are often missed by barium enema and therefore she decided to arrange a flexible sigmoidoscopy rather than a colonoscopy. If an abnormality had been identified on flexible sigmoidoscopy then a colonoscopy would not have been necessary. She could have asked for a colonoscopy to be performed while Mrs S was in hospital but she doubted that it would have taken place because the colonoscopists were extremely busy at that time. On 27 October she referred Mrs S to a Consultant Gastroenterologist (the Consultant Gastroenterologist) for a second opinion. She had no memory of being asked for a second opinion by Mr and Mrs S. It was up to the Consultant Gastroenterologist to decide how soon he should see Mrs S. However, her expectation was that the Consultant Gastroenterologist would see Mrs S before Christmas. She was not sure how she found out that he could not see Mrs S until February 1999 but thought that Mrs S's GP had telephoned her. She therefore decided to admit Mrs S again and referred her to the Second Consultant Surgeon on 9 December 1998.

12. The First Consultant Surgeon said that by December 1998 they had still not established the cause of Mrs S's problems and because of that she decided to review the x-rays. Prior to that she had only seen the x-ray reports. A Consultant Radiologist (the Consultant Radiologist) reported on 8 July 1998 that the barium enema x-ray taken on 2 July was normal. On 17 December the First Consultant recorded in the clinical notes 'Barium enema reviewed ?stricture ascending colon but reported as

normal'. The First Consultant said that on 17 December when she and her junior staff reviewed the barium enema films they wondered whether there might be a stricture in the ascending colon. However, they were not qualified radiologists. The consultant radiologists reviewed the x-ray and said that the x-ray showed only a spasm and that it was normal.

13. The First Consultant Surgeon said that on 17 December Mrs S was seen by the Second Consultant Surgeon. He was completely swamped by colo-rectal referrals at that time and Mrs S remained the First Consultant Surgeon's responsibility. There was a five week gap between being seen by the Second Consultant Surgeon and the colonoscopy going ahead. Two of those weeks would have been due to a close down over the Christmas period when only emergencies, that is patients with rectal bleeding, would be dealt with. Patients requiring colonoscopies which were urgent, such as Mrs S, would not have been taken. Colonoscopies were a particular problem because of the limited facilities and huge number of patients and therefore it was very difficult and still is very difficult to have a colonoscopy performed. There is only one unit with one room. The Victoria Infirmary is merging with the Southern General Hospital but this will not necessarily improve the colonoscopy situation. Correspondence with the Chief Executive about the problem had been going on for about five years.

14. **The Consultant Gastroenterologist** said during the Ombudsman's investigation that in 1998-1999 his waiting time was an average of 14 weeks. There were three colonoscopy experts, including himself, at the Infirmary at that time. Mrs S was referred to him by the First Consultant Surgeon in a letter dated 27 October 1998. He was asked to see her as an out-patient and there was no request to carry out a colonoscopy. Mrs S had been investigated and therefore a consultation and review of investigations with her seemed appropriate. He explained that invasive investigations such as colonoscopy are unpleasant for the patient and are not without considerable risk. For somebody who has already gone through a number of bowel preparations it would seem reasonable to justify to the patient and explain the risks before asking them to submit to such an investigation again. The appointment given to

Mrs S for February 1999 would have been the normal waiting time for his clinic at that time. Over the Christmas and New Year period due to public holidays clinics are lost. He thought that they had had to cancel two clinics. If he had decided, on the basis of the referral letter, to undertake a colonoscopy then it would have been possible to leap frog the waiting time to some extent by putting Mrs S on the colonoscopy waiting list but on the basis of the information he had, even if he had decided to do that, he would have graded the need as not very urgent. Even in hindsight given that Mrs S had undergone a fairly good range of tests he would have wanted to sit and talk to her before going ahead with a colonoscopy. By the time the GP's enquiry about the appointment date arrived [early December 1998] the clinics were already well overbooked and there was little likelihood of arranging a colonoscopy within the Festive period, and although Mrs S was not given an earlier appointment they had agreed to see her earlier if there were any cancellations.

Reports of the Ombudsman's Professional Assessors

15. I set out below **the First Assessor's report**:

Matters considered

(i) Matters considered were that the South Glasgow University NHS Trust took an unreasonable length of time to diagnose Mrs S's bowel cancer.

Basis of the report

(ii) Relevant documents including Mrs S's nursing and medical records, laboratory reports, radiology reports and general practice notes were made available to me by the Ombudsman's office.

Background based on the clinical chronology

(iii) Mrs S was referred on 13 February 1998 by her general practitioner with a two month history of intermittent low colicky abdominal pain with no upset in bowel habit and no PR bleeding.

She was assessed in the clinic on 31 March 1998 by the First Consultant Surgeon's Senior House Officer (SHO), who agreed with the general practitioner's diagnosis, but felt it important to exclude serious colonic disease with a barium enema and also arranged a pelvic ultrasound. The barium enema was arranged routinely and was performed on 2 July 1998, three months later. In the meantime the patient had not attended an outpatient appointment in June 1998; this is believed to be as there was some consultation with the Consultant's secretary over the fact that the tests had not yet at that stage been performed. She was seen back in the clinic on 25 August 1998 by the First Consultant Surgeon. She noted that she had no weight loss, no alteration in bowel habit and with a normal pelvic ultrasound and a normal barium enema, as reported at that stage, felt able to discharge the patient.

(iv) *The patient was re-referred by the general practitioner on 15 September 1998, this time further complaining of severe lower abdominal pain, breathlessness and with a haemoglobin of 8.1g/l. She was reviewed urgently in the clinic by a Surgical SHO, who felt that she warranted an upper gastrointestinal endoscopy. He arranged this for 5 October 1998 and this was found to be normal.*

(v) *She was reviewed by the First Consultant Surgeon on 6 October 1998 and transfused with three units of blood. On 7 October 1998, the First Consultant Surgeon arranged for her to have a small bowel follow through examination and booked a flexible sigmoidoscopy for the forthcoming week.*

(vi) *Mrs S was allowed home and re-admitted the following Wednesday for these procedures. She was re-admitted on 14 October 1998, and had a flexible sigmoidoscopy carried out the next day on 15 October 1998. She had a normal flexible sigmoidoscopy to 60 cm with random biopsies.*

(vii) *Her barium meal and follow through was booked for 16 October 1998 which showed no abnormality of the small bowel to explain the anaemia.*

(viii) *She was reviewed again in the clinic on 27 October 1998. Her faecal occult bloods were in the notes as positive at this stage and the First Consultant Surgeon wrote to the general practitioner detailing the iron deficiency anaemia and the fact that so far no abnormality had been found despite a barium follow through, gastroscopy, and two abdominal ultrasounds. She informed the general practitioner that she was going to seek a second opinion from one of her gastroenterology colleagues. She wrote to the Consultant Gastroenterologist on 27 October 1998 and asked the Consultant Gastroenterologist if he would give a second opinion on Mrs S's iron deficiency anaemia for which a cause, as yet, had not yet been found.*

(ix) *On 4 December 1998, in response to a letter from Mrs S's general practitioner, asking for her appointment for the second opinion to be expedited, the Consultant Gastroenterologist wrote back saying that she had been fully investigated by a surgical colleague and that there was no indication for an appointment to be brought forward. He did, however, say that if there were any cancellations in his clinic, he would make efforts for the appointment to be brought forward.*

(x) *In response to this the First Consultant Surgeon re-admitted the patient on 9 December 1998 for further investigation of her anaemia. At this stage she had a further upper GI endoscopy which was also normal. Further, her right-sided abdominal pain was also becoming more difficult to control and attempts were made to manage this with painkillers and a TENS machine, with little effect.*

(xi) *On 23 December 1998, whilst still an inpatient, a red cell scan was arranged to see if there was any bleeding in the large bowel*

and this was found to be inconclusive. On the ward round on 17 December 1998, the First Consultant Surgeon made an annotation that she was concerned that there might be a stricture on the right side of the colon. However she noted that it was reported as normal. Again on 17 December, the Second Consultant Surgeon attended to provide a second opinion, as requested by the First Consultant Surgeon, and he said that the patient should have a colonoscopy, arranged by the Registrar, and the faecal occult bloods repeated after the special diet. They remained positive after the special diet. Mrs S had a red cell scan performed which again was inconclusive.

(xii) *She was allowed home over the Christmas period and was re-admitted on 20 January 1999 for colonoscopy. Sadly the first colonoscopy was hampered by the poor bowel preparation and was unsuccessful. She was re-admitted a week later on 27 January 1999 and had a further colonoscopy on 28 January 1999, which confirmed a right sided bowel tumour which was confirmed the next day to be a moderately differentiated adenocarcinoma on biopsy. The patient was counselled by the First Consultant Surgeon on her findings and that she required a right hemicolectomy and possible chemotherapy, depending on the histology after the bowel was removed.*

(xiii) *The patient was re-admitted on 5 February 1999 and had a right hemicolectomy performed on 8 February 1999. Histology confirmed the tumour to be a Dukes C adenocarcinoma and she was referred for chemotherapy.*

(xiv) *The family expressed some concerns over the delay in diagnosis of the cancer, but they were counselled by the First Consultant Surgeon on the investigations to date and the fact that there was no sign of the cancer on her previous barium enema examination. Sadly Mrs S ultimately developed multiple metastases from her colorectal cancer and died as a consequence.*

Assessor's comments on the actions of clinical staff

(xv) *In this report I am commenting on the management of Mrs S between her initial presentation and her operation to excise her right-sided colonic cancer and will not be addressing any other aspects of her care.*

(xvi) *At her initial presentation on 31 March 1998, Mr S had had an appropriate history taken by the SHO and indeed an appropriate examination had been performed. Although the examination findings were negative, the SHO had appropriately arranged for her to have investigations, including a barium enema and a pelvic ultrasound scan to assess her abdominal pain. In the absence of rectal bleeding the decision not to check her haemoglobin was reasonable. The patient was initially intended for review in June 1998, but as her barium enema had still not been performed, this was put back to 25 August 1998. Her normal pelvic ultrasound and barium enema were accepted by the First Consultant Surgeon and she was discharged. I feel that this was an entirely reasonable decision given the presentation with abdominal pain, with no associated bleeding and having had no family history of colorectal cancer and previous investigations for a similar pain, which had yielded no pathology in the past. The three month delay in the barium enema being performed is completely within national averages and the times between GP referrals and actually being seen in outpatients was again very acceptable.*

(xvii) *On Mrs S's second presentation, she was seen within 14 days of her urgent general practitioner referral on 29 September 1998 and an admission was arranged for investigation. During this admission she had a gastroscopy performed, a barium meal and follow through performed, a flexible sigmoidoscopy and faecal occult bloods. No positive findings were made on any of these investigations and as a consequence of this a second opinion was sought from the Consultant Gastroenterologist.*

(xviii) *In my opinion the performance of a gastroscopy and barium meal and follow through were entirely justifiable. The First Consultant Surgeon clearly was questioning whether there could be a missed colonic lesion to explain the anaemia and performed a flexible sigmoidoscopy. This also was normal. Faecal occult bloods were performed which again were positive further reinforcing the likelihood of a gastrointestinal source of the bleeding which had so far been missed.*

(xix) *It is my opinion that having raised the possibility that there could be an occult source of bleeding within the colon, not picked up on the barium enema, a better choice would have been for the patient to have a colonoscopy, which would, in all likelihood, have revealed at this stage the presence of her colorectal cancer. However the First Consultant Surgeon is clear that the waiting times for colonoscopy were six months at this stage and if she had requested a colonoscopy it would not have been done within an acceptable time frame. Given this she accepts that barium enemas do miss colonic lesions more commonly than colonoscopy and that one of the most common sites for these to be missed is the sigmoid colon. Therefore a flexible sigmoidoscopy was performed in order to rule this out as a possibility.*

(xx) *It seems therefore that the non-performance of a colonoscopy during this admission was due to lack of resources at the Victoria Infirmary for performing colonoscopy at this stage. We questioned the First Consultant Surgeon carefully on this and she informed us that letters had been sent by the Clinical Director of Surgery to the Management explaining to them the surgical unit's gross concerns over the lack of colonoscopic resources. She felt that the best way of arranging appropriate further investigations, and indeed the quickest way, would be to refer Mrs S to the Consultant Gastroenterologist colleague. At that stage a referral letter was written to the Consultant Gastroenterologist asking him to assess this lady with unexplained anaemia, although colonoscopy was not expressly requested in the consultation.*

Delay consequent upon referral to the Consultant Gastroenterologist

(xxi) *Mrs S was not reviewed by the Consultant Gastroenterologist at all and indeed a letter was sent by Mrs S's general practitioner to the Consultant Gastroenterologist on 4 December 1998 when the general practitioner became concerned over the delay in seeing the Consultant Gastroenterologist. At that stage the Consultant Gastroenterologist had written back saying that the patient had already been fully investigated by his surgical colleague, including barium enemas and barium meal follow through and he did not think that the appointment needed to be expedited beyond standard appointment, despite her concurrent anaemia. We have discussed this issue with the Consultant Gastroenterologist who informs us that as he had the Christmas period approaching, he had two clinics being docked by Bank Holidays, and he thought this lady was less likely to have a serious pathology than other people waiting for his clinic. Therefore he did not feel he could jeopardise their care by putting her higher up on the queuing system.*

(xxii) *My opinion is that the Consultant Gastroenterologist could have been more flexible in recognising that this was a patient who was definitely anaemic, had faecal occult blood positivity, despite negative investigations and therefore, especially given the concerns expressed by the general practitioner, would have been most appropriately seen urgently. I feel Mrs S could have reasonably expected to have been reviewed earlier in the clinic, which may have resulted in expediting the diagnosis of her colorectal cancer by a colonoscopy. Further, the First Consultant Surgeon could have made it clearer in her referral letter to the Consultant Gastroenterologist that she wished to have an urgent appointment and indeed that she could have directly requested colonoscopy at this stage. Improved communication at this stage may well have led to a swifter diagnosis of the lady's pathology.*

Re-admission December 1998

(xxiii) *The First Consultant Surgeon is uncertain as to how she became aware of the fact that the patient had not as yet been reviewed by the Consultant Gastroenterologist, but it is likely that the general practitioner contacted her. The First Consultant Surgeon acted swiftly at this stage and arranged a further admission for the patient, where the aforementioned investigations were performed in December including further faecal occult bloods, another upper GI endoscopy and another flexible sigmoidoscopy. She also had nuclear medicine scans performed at that stage and an appropriate second opinion was now sought from a different route and the Second Consultant Surgeon with an interest in colorectal diseases, reviewed the patient on 17 December 1998. He requested that a colonoscopy be ordered but did not take over the patient.*

<u>Re-admission January 1999</u>

(xxiv) *The patient was re-admitted on 20 January 1999, some five weeks after the colonoscopy had been requested. Colonoscopy was attempted but initially failed but the second colonoscopy a week later confirmed the presence of a tumour.*

(xxv) *It is my opinion that this five week delay in a patient with confirmed anaemia was unreasonable. The patient could have reasonably expected to have had a colonoscopy performed while an inpatient at that stage or at an earlier date than five weeks later. It is to be noted that this was over the Christmas period but nonetheless we have a lady here with considerable reasons for concern, with continued anaemia, right-sided abdominal pain and who was not settling. Having enquired of the involved parties why this delay was present, it was again one of a lack of resource with the Second Consultant Surgeon being overwhelmed, in the First Consultant Surgeon's opinion, with colorectal work at that stage and there simply was no adequate resources to expedite this colonoscopy. A repeat barium enema would have been just as delayed at this stage.*

Surgery and counselling of relatives

(xxvi) *The First Consultant Surgeon performed a right hemicolectomy on Mrs S in early February 1999 and found her to have a Dukes C adenocarcinoma which was curatively excised. The patient's relatives expressed their concern over the delay in the diagnosis at this stage but the First Consultant Surgeon reassured them that until then there had been no evidence of a right sided lesion on any of the investigations. Close examination of the case sheets had revealed the First Consultant Surgeon to have concerns that there might be a right-sided colonic lesion and this is recorded in the notes on 17 December 1998. When we questioned why the First Consultant Surgeon had not shared this information with the family, she informed us that she had discussed the x-rays further at an x-ray meeting. She had been reassured once again by the radiology department that there were no abnormalities in the colon. She was a Consultant Surgeon and not a Consultant Radiologist and therefore had to take the opinion of the experts in the field. Certainly on my review of the x-rays, I was concerned they indicated that there was an abnormality. This issue of the presence of the lesion or not on initial barium enema has been addressed by a further expert assessor in radiology (report at paragraph 16).*

Conclusions

(xxvii) *In conclusion therefore I feel that Mrs S's diagnosis of colorectal cancer was unduly delayed. I think her initial presentation was well managed and appropriate, but when she was re-admitted with her iron deficiency anaemia, it would have been reasonable to further investigate her colon. It is well recognised that barium enemas have a sensitivity rate of 93% and therefore can miss lesions. Therefore when all other areas had been examined by upper GI endoscopy, barium meal and follow through, it would have been appropriate to further examine her gastrointestinal tract, either by a further barium enema or by a colonoscopy. Sadly the lack of resources in colonic imaging, in the Victoria Infirmary at this stage seemed to have been the rate limiting*

step and the First Consultant Surgeon did indeed try to survey what she could of the colon with a flexible sigmoidoscopy.

(xxviii) *Referral for a second opinion sadly resulted in a further ten week delay, as a second opinion was not provided as an emergency, despite a further request by the general practitioner. Improved communication between the First Consultant Surgeon and the Consultant Gastroenterologist, and indeed the Consultant Gastroenterologist placing more emphasis on the second opinion request from a colleague and indeed a further request from the general practitioner, to expedite that opinion may well have resulted in an earlier colonic imaging and therefore an earlier diagnosis. I think it would not have been unreasonable for Mrs S's case to have been dealt with more expeditiously than this.*

(xxix) *The First Consultant Surgeon acted promptly and appropriately to re-admit Mrs S when she became aware of these delays in treatment and arranged a second opinion from the Second Consultant Surgeon. He reviewed the patient on 17 December 1998 and requested a colonoscopy to be booked. She was not re-admitted for the colonoscopy until 20 January 1999, some five weeks later. This was despite the fact that this was clearly a clinically difficult patient with a right-sided abdominal pain and anaemia. Once again there has been a demonstrable lack of resource in colonic imaging which has led to an unreasonable delay of five weeks in having a colonoscopy. During that admission, had resources been available, Mrs S should have had an emergency colonoscopy. When the diagnosis had been established on 28 January 1999, the further investigations and treatments were carried out expeditiously and appropriately.*

(xxx) *In short, I feel that Mrs S's care has been unduly delayed since her re-presentation in September 1998 with iron deficiency anaemia. The lack of colonic imaging resources in the South Glasgow Trust, at that stage, is a cause for great concern and I can see no reason why such an incident could not occur again*

unless access to colonoscopic and barium enema investigations is not addressed. Preliminary enquiries into this have yielded the information that merging with the Southern General Hospital may give more endoscopy slots but still the presence of only one endoscopy room in a major hospital seems very under resourced. Barium enemas have had a lot of resources provided, according to the First Consultant Surgeon, and at one time the waiting time had dropped from six months to six weeks, although I am aware that this is now climbing back up again. I think it is important that the colorectal imaging service is maintained in a reasonable and prompt state, as six month delays for both colonoscopy and for barium enema can only result in further such cases as we have seen.

16. I set out below **the Second Assessor's report**:

Matters considered

(i) *Mr S made a complaint against South Glasgow University Hospitals NHS Trust concerning the investigation of his wife's abdominal symptoms. He maintained that the Trust took an unreasonable length of time to diagnose Mrs S's bowel cancer.*

(ii) *During the course of her clinical investigations Mrs S underwent a barium enema that was reported as normal. During the investigation into Mr S's complaint the barium enema was reviewed by a senior clinician and the matter was raised as to whether the study should have been reported as normal and whether a bowel cancer had been missed on the study.*

Basis of report

(iii) *My remit is not to look at the whole management and investigation of the patient and any delays that may have occurred but to focus on the barium enema study that was performed. In particular I was asked to assess whether the*

bowel cancer had been missed and whether the standard of the radiological procedure and reporting were within acceptable limits. To this effect I was sent copies of the papers pertaining to the case and a copy of the barium enema in question.

The barium enema

(iv) *Mrs S was referred to the First Consultant Surgeon by her GP in March 1998 with what appears to be longstanding symptoms which had been previously investigated. A barium enema was arranged. There were no particular features to suggest a serious disease such as cancer and Mrs S was placed on the routine waiting list. There was a wait of four months for the barium enema study. This sort of delay is very common in x-ray departments for this type of investigation. A barium enema involves giving the patient medicine to 'clear the bowel out'. A thin tube is put into the back passage through which first a white liquid suspension containing barium followed by air or CO_2 are introduced. The whole of the colon or large bowel are outlined by the barium and air. Barium shows up well on x-rays and during the study a series of x-rays are taken in an attempt to visualise the whole of the large bowel. When a barium enema is performed a series of films are taken with the purpose of seeing all parts of the large bowel well. Individual images need to be interpreted in the light of the whole study as the bowel can collapse and spasm and sometimes look quite abnormal on individual films. There is no single recognised series of films which are considered mandatory for a good quality barium enema and the actual films taken vary considerably between departments and within departments depending on the type of radiology equipment available, the patient's clinical condition and individual preference of the radiologist.*

(v) *Bowel symptoms are very common and are not usually due to cancer. Symptoms due to cancer are often non-specific and the main reason for doing barium enemas is to make sure that there is no cancer. Less than one in 20 barium enemas will show*

cancer. No cancer was seen on Mrs S's enema on 2 July 1998. The report was however a little unusual. The final sentence read 'No other large bowel abnormality is identified'. No large bowel abnormality has been described so the presumption is that this is a typing error which has been overlooked rather than following on from a sentence which has been omitted.

(vi) *Mrs S re-presented with further symptoms in September 1998 and in January 1999 a cancer of the ascending colon was found at colonoscopy. Bowel cancers are usually slow growing and are often present for several years before they are detected. It is generally considered that if a barium enema which did not show cancer has been performed in the 12 months prior to a diagnosis of bowel cancer then the cancer was very likely to have been present at the time of that barium enema. Several studies including a regional audit in the area in which I work have shown that between 2-5% of bowel cancers are missed at barium enema using these criteria. When the x-ray films of these patients are reviewed with the knowledge of the site of the tumour about half the cancers can be seen in retrospect (perceptive misses) and about half are not visible (technical misses). Given that Mrs S's barium enema was performed about six months before the diagnosis of her cancer it is probable therefore that the cancer was present at the time of the study.*

(vii) *On two occasions clinicians have looked at Mrs S's barium enema films and thought that they were abnormal. The other external assessor looking at the case thought that they were abnormal (see paragraph 15(xxxvi) and the First Consultant Surgeon wrote in the clinical notes on 17 December 1998 'barium enema reviewed ?Stricture ascending colon but reported as normal'. With this in mind I reviewed the patient's films.*

(viii) *The films taken during Mrs S's barium enema are considered of good quality and the protocol employed is well within accepted norms. In Mrs S's barium enema there is one of the large images*

(the right decubitus film, taken with the patient lying on her right side) where the ascending colon looks very narrow. I presume that this is the film which was considered abnormal by both surgeons. A radiologist reviewing this film would look at the other films of the same region to determine whether the finding was persistent. The other film which shows the area well is the left decubitus taken with the patient lying on her left side. That film shows that the bowel is now very well distended which would have reassured the radiologist. I expect that the radiologist who reviewed the films in December 1998 after the possibility of stricture was raised did just that and that that is what was done at the time of the original study. Unfortunately that is the area where the cancer was found and the well distended film is rather over-penetrated which makes fine detail hard to assess. There are two other images of the area taken by the doctor earlier in the study. They both also show the ascending colon well distended. Knowing that there is a cancer there, there is an area in the ascending colon which I am fairly sure is the cancer. It is not easy to see and it is always much easier to identify these lesions in retrospect. I showed the whole set of films (anonymised) to several of my radiologist consultant colleagues. Two of them did identify the lesion but several did not. In my opinion the cancer can be seen in retrospect but the appearances are subtle and it is understandable that it was not identified on the initial study.

<u>Conclusion</u>

(ix) *Given that the barium enema was performed within a year of the diagnosis of bowel cancer the cancer was almost certainly present at the time of the study. On review of the films the cancer is probably visible but not easily detected even in retrospect and falls within the accepted class of 'perceptive miss' [see paragraph (vi)]. It is therefore my opinion that the radiology procedure and reporting was within acceptable limits.*

Findings

17. Mrs S first attended at the First Consultant Surgeon's clinic on 31 March 1998. The cancer was subsequently diagnosed on 28 January 1999. Mr S considered that there was a lack of urgency on the part of the First Consultant Surgeon and that she cannot have undertaken the correct investigations and also that she should have referred Mrs S to the Second Consultant Surgeon earlier.

18. It is evident that although the barium enema that took place on 2 July 1998 was reported as normal, the First Consultant Surgeon on reviewing the x-ray in December 1998 was concerned that it might show an abnormality and the Ombudsman's First Assessor had similar concerns. As a result the Second Assessor, a Consultant Radiologist, was appointed to advise on the x-ray. He produced a report (reproduced at paragraph 16) explaining his findings in detail. His conclusion, which I accept, was that the radiology procedure and reporting was within acceptable limits. I am therefore satisfied that although in hindsight the cancer was probably visible on that x-ray, the x-ray report dated 8 July 1998 is not open to criticism. The Ombudsman's First Assessor said that, for the reasons explained in his report [paragraph 16(xvi)] Mrs S's first presentation, that is her care between 31 March and 25 August, was well managed and appropriate and the decision to discharge her on 25 August was reasonable. I accept that advice.

19. I note that when Mrs S was referred back to the First Consultant Surgeon in September 1998 the First Consultant was concerned and so arranged Mrs S's admission for further tests. During Mrs S's admission to the Infirmary in October the First Consultant Surgeon said she opted for a flexible sigmoidoscopy because the sigmoid colon is the area in which lesions are often missed by barium enema. If an abnormality had been identified on a flexible sigmoidoscopy then a colonoscopy which, I understand, needs better preparation, takes longer to perform and is slightly more hazardous, would not have been necessary. A flexible sigmoidoscopy examines the lower third of the colon whereas a colonoscopy examines the whole length of the colon. The First Assessor considers that, given the possibility of an occult (hidden) source of

bleeding in the colon, then the optimal choice of investigation would have been a colonoscopy which would almost certainly have revealed the cancer. However, he also acknowledges the difficulties in obtaining colonoscopies.

20. Another opportunity to diagnose Mrs S's condition occurred after the First Consultant Surgeon referred Mrs S to the Consultant Gastroenterologist in October 1998 for a second opinion. The First Consultant Surgeon did not indicate any urgency in the referral letter and said that it was up to the Consultant Gastroenterologist to decide how soon to see Mrs S. She assumed the Consultant Gastroenterologist would see Mrs S before Christmas. For the reasons given in paragraph 14, the Consultant Gastroenterologist decided not to expedite Mrs S's appointment and added her to the normal waiting list meaning that he would not see her until February 1999. Only after representations by Mrs S's GP did the First Consultant Surgeon become aware of the situation and intervened and arranged for Mrs S's admission to hospital and for her to be seen by the Second Consultant Surgeon. The First Assessor [paragraph 15(xxi) and (xxii)] considered that the Consultant Gastroenterologist should have treated the referral with more urgency and that the First Consultant Surgeon could have indicated in her letter that she regarded the referral as urgent. I fully endorse the Assessor's comment that better communication between the two Consultants at this stage could have expedited the diagnosis of Mrs S's cancer.

21. Finally, in December, after the Second Consultant Surgeon decided to arrange a colonoscopy there was a five week delay before it took place apparently due to lack of resources. The First Assessor described the delay as unreasonable [paragraph 15(xxv)] and considered it should have been possible to perform the colonoscopy while Mrs S was an inpatient. The First Assessor's conclusion, which I accept, was that Mrs S's diagnosis was unduly delayed after her re-presentation in September. **I uphold the complaint.**

22. I am also very concerned by the First Assessor's comments on the apparently long-running lack of colonic imaging resources in the Trust

[paragraph 15(xxx)] which clearly contributed to the delay in this case. In addition there was also a wait of three months for a barium enema study although I note that the Second Assessor advises that this sort of delay is very common in x-ray departments for this type of investigation [paragraph 16(iv)]. I **recommend** that the Trust review the adequacy of the colonoscopy service provided for patients and also consider whether waiting times for barium enema studies can be reduced. I also **recommend** that the Trust review the adequacy of communication between Consultants in the event of referrals and consider how to ensure that the degree of urgency of referrals is conveyed and understood.

Conclusion

23. I have set out my findings in paragraph 18 to 22. The Trust has asked me to convey – as I do through my report – its apologies to Mr S for the shortcomings I have identified. The Trust has also agreed to implement the recommendations in paragraph 22.

Gillian Stewart
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services
Ombudsman Act 2002

29 September 2003

Glossary of medical terms

adenocarcinoma – moderately differentiated	this is a slow growing and common type of colon cancer
adjuvant chemotherapy	chemotherapy that is given after surgery for colon cancer if there is no sign of spread at operation, but if the cancer has grown through the bowel wall
anaemia	lowering of the haemoglobin (red blood cell) level, often, as here due to continued bleeding
barium enema	an x-ray examination of the colon (large intestine) after rectal instillation of barium sulphate
caecum	the beginning of the colon where the small bowel enters it, and where the appendix is situated
colonoscopy	examination of the whole length of the colon by an instrument inserted through the anus
decubitus	lying down position
endoscopy	an examination of the bowel by looking into the bowel cavity with a flexible fibre-optic instrument, either through the mouth (Gastroscopy, or oesopho-gastro-duodenoscopy [or OGD]) or rectum

	(colonoscopy)
ESR (erythrocyte sedimentation rate)	a possible indication of infection
faecal occult bloods	blood in the stool that cannot be seen but can be detected by chemical tests
gastroscopy	examination of the inside of the stomach
haemoglobin levels	the level of red blood cells in the blood, lowered in anaemia
hemicolectomy	surgical removal of half of the colon
iliac fossa	area of the lower abdomen
irritable bowel syndrome	a common condition where the function of the bowel is disturbed and the patient experiences colic, distension, and either diarrhoea or constipation, or both. It is not caused by a diseased bowel, but the symptoms necessitate bowel investigations to make sure that there is no bowel disease present
metastases	the movement or spread of cancer cells from one organ or tissue to another
pelvic ultrasound	ultrasound scan of the organs in the pelvis - rectum, bladder, uterus etc
PR bleeding	obvious ie not occult, bleeding *per rectum*
sigmoidoscopy	examination of the lower third of the colon by an instrument inserted through the anus

spasm	an involuntary contraction of muscle
stricture	an abnormal narrowing
TENS machine	trans-epidermal neural stimulation - the machine is a small battery operated one, stimulating the nerves of sensation with electricity, used for pain relief.