SPSO decision report

Case: **201004820, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, recommendations

Summary

Ms C attended the accident and emergency department of a hospital with abdominal pain three times in two months. Clinicians diagnosed a possible urinary infection and discharged her with pain relief. Ms C complained about the care and treatment she received during these visits to hospital. She said that clinicians failed to investigate her symptoms properly and arrange appropriate referrals.

Ms C had an ultrasound scan a couple of months later, which identified fibroids (non-cancerous tumours that grow in or around the womb) and a mass near her pelvis. This was confirmed by an MRI scan which was taken shortly after. Ms C complained that the board's response to the ultrasound scan lacked urgency and that a more senior doctor should have looked at it to avoid the need for an MRI scan.

About two months later, a consultant gynaecologist reviewed Ms C and provisionally diagnosed a degenerating fibroid. Ms C underwent a full hysterectomy (removal of the womb) shortly after. During the operation, numerous fibroids were noted in addition to a large mass, and it was later confirmed that the mass was a tumour. Ms C complained that she underwent a hysterectomy that might not have been necessary and which could have been avoided if she had been referred to an oncologist and/or had a biopsy carried out beforehand. She also complained about the board's response to her complaint saying that it contained a number of inaccuracies.

We upheld two of Ms C's complaints. After taking advice from our medical adviser, we found that she should have been reviewed by a more senior doctor when she went back to the hospital with the same problem. The adviser also said that the doctor concerned should have widened the range of possible diagnoses they were considering, after the results of a dipstick test ruled out a urinary tract infection. However, we found that their response to the ultrasound

scan was reasonable and that ordering an MRI scan as a result was appropriate. We also found that the decision not to involve oncology or conduct a biopsy was reasonable in light of Ms C's presenting condition at the time, as was the decision to proceed with a hysterectomy.

Finally, although we found that much of the board's response was accurate, it did contain two inaccuracies. More seriously, the board did not respond appropriately to Ms C's complaint about her hysterectomy.

Recommendations

We recommended that the board:

- forward a copy of the decision letter and Ms C's letters of complaint to the relevant clinician to reflect on;
- draw up a written policy clearly stating the need for senior review when a patient presents to accident and emergency complaining of the same problem; and
- apologise to Ms C for the inaccuracies contained in their response and their failure to provide a substantive response to her concerns about her hysterectomy.