SPSO decision report

Case: **201203532, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C, who is an advocacy worker, complained on behalf of the partner of Mr A that the board failed to provide Mr A with an appropriate level of treatment. Mr A was admitted to a hospital's acute medical assessment unit with chest pain. He was transferred to the care of cardiologists (specialists dealing with disorders of the heart) who noted that he had severely high blood pressure. He was treated as having acute coronary syndrome (a medical term used when doctors believe that the patient has a serious problem with the narrowing of one or more of the coronary arteries) because of an elevated serum troponin (this is present in the bloodstream when there has been damage to the heart).

An echocardiogram (an instrument for diagnosing heart abnormalities that uses reflected ultrasonic waves to show the structures and functioning of the heart) was carried out at Mr A's bedside on the day of his admission. Two days later, he was sent for a further echocardiogram. This showed the presence of a tear in the ascending aorta (a portion of the large artery that carries blood from the left ventricle of the heart to branch arteries). A CT scan (a procedure that uses x-rays to define normal and abnormal structures in the body) was performed the same morning confirming the diagnosis of aortic dissection. Arrangements were made for Mr A to undergo surgery that day, but he died in the anaesthetic room before the operation could begin.

We took independent advice from one of our medical advisers, who said that aortic dissection is a rare condition and it is not unusual for the diagnosis of it to be missed. This is because unless a CT scan or, as in Mr A's case an echocardiogram, is performed there may be no specific pointers away from the presumed diagnosis of acute coronary syndrome. For most patients, it is relatively unlikely that a chest CT scan would be performed on a routine or even random basis. Although the fact that Mr A was at risk of aortic dissection was not picked up from the first echocardiogram, there was no recording of this and it was possible in any case that the tear developed after this had taken place.

Mr A had to wait for his operation because it was the holiday period and there was only one surgeon on call, who was in the middle of an operation. We found that it was not unreasonable that the cardiac surgeon completed the operation he was performing, before operating on Mr A. It was also likely that Mr A would have died before an operation could have been performed if he had transferred to another cardiac surgical centre. Mr A was in the acute phase and needed a very high-risk operation. In addition, we considered that Mr A had received the correct medication to lower his blood pressure and relieve his chest pain.

We found that overall, the actions of the doctors were reasonable and appropriate and we did not consider that there were any unnecessary delays.