SPSO decision report

Case: **201204705, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C's father (Mr A) has a complex medical history, including cancer. Early in 2012, Mr A began to suffer backache, and a GP visited him at home. The GP believed the problem was musculoskeletal and prescribed anti-inflammatory gel and pain relief (tramadol). Mr A continued to suffer a great deal of pain and went to the medical practice three days later. The GP saw no obvious signs of infection and diagnosed muscular pain, but also took blood tests to exclude any spread of the cancer. Mr A continued to suffer severe pain and was reviewed by the GP again over the next few weeks. The GP arranged for a chest x-ray and, when the results for this were abnormal, arranged for Mr A to have a scan.

On the day the scan was due, Mr A also had an appointment at a cancer centre, which he attended on his GP's advice. Because of the appointment, the scan was carried out seven days later than planned. The scan results were also abnormal, suggesting possible malignancy or infection in the spine (discitis). The GP urgently referred Mr A to the oncology (cancer) department at the hospital. Mrs C said that Mr A's pain became excruciating and over several weeks increasingly strong painkillers were prescribed. He was then admitted to hospital by ambulance and diagnosed with discitis. After further investigations and treatment (including an operation) Mr A lost the use of both legs and became doubly incontinent.

Mrs C complained that the GP failed to properly investigate her father's symptoms, provide reasonable pain relief and admit him to hospital, and that the delay in diagnosis was not reasonable. She said that had the relevant scans been carried out sooner, then the outcome for Mr A would have been more positive. She was also unhappy that Mr A's attendance at the cancer centre meant a delay in the scan being carried out.

We took independent advice on this complaint from one of our medical advisers. With hindsight, the significance of the delay in Mr A having a scan, caused by the cancer centre appointment, was apparent. However, what we had to consider was whether the GP's advice that the appointment at the centre should be kept was reasonable in light of the information available to him at that time. Given that this arose from the GP's concern that the abnormality indicated in the x-ray was a spread of cancer (which our adviser said was a reasonable working diagnosis at that time) we were satisfied that his advice was appropriate in the circumstances. On the delay in diagnosis, our adviser said that while discitis is a rare and difficult condition to diagnose (particularly in general practice), there was a delay in carrying out appropriate investigations, in that an x-ray should have been carried out two weeks earlier. However, the adviser also told us that the pain relief was appropriate and that the decision not to admit Mr A to hospital earlier was reasonable. Nevertheless, we were concerned about the delay in arranging a chest x-ray, particularly in light of Mr A's complex medical history, and the impact this had on him. We upheld Mrs C's complaint and made recommendations.

Recommendations

We recommended that the practice:

- review the handling of Mr A's case in light of the findings of our investigation; and

- apologise to Mrs C for the failures identified.