

Scottish Parliament Region: North East Scotland

Case 200600187: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology

Overview

The complainant (Ms C) raised a number of concerns about her mother (Mrs A)'s care and treatment at Aberdeen Royal Infirmary (the Hospital). In particular, she wondered whether Mrs A's cancer could have been diagnosed a few months earlier and whether this would have affected the sad outcome for her mother, who died, aged 60, in October 2005, the day after being temporarily discharged whilst waiting for the result of a biopsy.

Specific complaint and conclusion

The complaint which has been investigated is that Mrs A's care and treatment at the Hospital from July 2005 to October 2005 were inappropriate (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. The Ombudsman received Ms C's complaint on 19 April 2006. Ms C had a number of concerns about Aberdeen Royal Infirmary (the Hospital)'s care and treatment of her mother (Mrs A) from July to October 2005. Mrs A's carcinoma (a cancer) of the pancreas, with secondary deposits in the liver, was diagnosed just weeks before her death on 26 October 2005, aged 60. The heart of Ms C's complaint is whether a diagnosis could have been made in July 2005 and, if so, whether it could have affected the sad outcome for her mother.

2. The complaint from Ms C which I have investigated is that Mrs A's care and treatment at the Hospital from July 2005 to October 2005 were inappropriate.

Investigation

3. I was assisted in the investigation by two clinical advisers, a consultant physician and a consultant radiologist, whom I shall refer to as the Advisers. Their role was to explain and comment on the overall standard of Mrs A's medical treatment and whether the cancer could have been diagnosed in July 2005. We examined the papers provided by Ms C and complaint correspondence, Hospital clinical records and other information provided by Grampian NHS Board (the Board). In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within the boundaries of what would have been considered to be acceptable practice in terms of knowledge and practice at the time in question.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Mrs A's care and treatment at the Hospital from July 2005 to October 2005 were inappropriate

5. I turn now to the complaint and shall first cover July 2005. A reminder of the terms used is at Annex 1. Mrs A was a Hospital in-patient from 5 to 7 July 2005, having been admitted with upper abdominal pain. An ultrasound scan showed a gallstone (a small, hard, mass in the gall bladder), and an

endoscopy (inspection inside the stomach and upper small intestine) showed inflammation in the stomach and duodenum. A biopsy (a tissue sample) of the stomach lining was taken for a particular test (called a CLO test), which is used to identify the presence of a bacterium which is associated with peptic ulcers. On 26 July, a computed tomography scan (CT scan) of the abdomen was done and showed the same features as the ultrasound scan.

6. A consultant's letter in August 2005 said that she could not find the CLO result. I mention the CLO test in this report only because Ms C's particular concerns with the events of July 2005 were whether a diagnosis of cancer could have been made from it and, if so, whether that could have produced a better outcome for her mother. The Board have acknowledged to me that there is no record of the CLO test result having been recorded.

7. I summarise in this paragraph the Advisers' comments in relation to July 2005:

'In respect of the issues complained of, the ultrasound was normal, particularly in respect of the pancreas. The CT showed extensive fatty changes in the liver but a normal pancreas. Even searching the CT with the benefit of hindsight, we could identify no form of pancreatic mass. The lesion which was found in a CT scan in October 2005 was definitely not visible in July. The equipment used by the Hospital was, for 2005, top of the range. And there was no additional investigative technique that could or should have been used.

In conclusion, in July 2005 Mrs A had an entirely appropriate and technically satisfactory investigation, performed with a view to excluding carcinoma of the pancreas. The investigation showed no evidence of such a tumour, and it is clear from later events that what developed later was a very aggressive and fast growing lesion.

Clearly, it is regrettable when test results are not recorded, and the Ombudsman's office would not condone this. This was clearly important to Ms C because she wondered if it delayed her mother's diagnosis and, therefore, if it contributed to her mother's death. We can reassure Ms C entirely on this point. The CLO test result would have had no bearing on the subsequent diagnosis of cancer of the pancreas. As indicated at paragraph 5, it was a test to identify something associated with ulcers and would simply have prompted medical attention towards curing the

inflammation (see paragraph 5) that the endoscopy had revealed in the stomach and duodenum.'

8. Turning now to October 2005, I note that Mrs A was admitted to the Hospital on the 12th, with swelling of the right leg, which ultrasound identified as a deep vein thrombosis (DVT). Mrs A also spoke of shortness of breath, abdominal pain (which was thought to be caused by the gallstone), poor appetite, nausea, and bleeding from the rectum (the final part of the large intestine, terminating at the anus). The shortness of breath suggested a possible pulmonary embolus (a blood clot causing an obstruction in the lungs). A scan confirmed this, and she was treated with an anticoagulant drug to try to clear it. Following a concern of Ms C's about that drug's dosage, the Advisers confirm that (as well as being an appropriate choice of medication), Mrs A was given the correct dose for her weight. On 17 October 2005 an ultrasound scan showed multiple lesions in the liver, which looked likely to be cancerous, and also a suggestion of an abnormal pancreas.

9. The clinical records say that a locum consultant physician at the Hospital (the Consultant) reviewed Mrs A and, on 18 October, told Ms C that the diagnosis was cancer, that its primary site was not certain, that there was unlikely to be any suitable treatment and that the prognosis was a matter of months, rather than years. At Ms C's request, I record here her recollection that he said he thought Mrs A had cancer, rather than giving an actual diagnosis, and that he gave a prognosis of only weeks. Having thought the problem was Mrs A's gallstone, Ms C was upset at being given such unexpected news on a busy ward, with only a drawn bed curtain for privacy. And she could not understand how the Consultant could know there was no treatment if he did not even know the cancer's location. The Board told Ms C that, although staff try, it is not always possible to find a private area in which to give distressing news. I acknowledge that it is not ideal simply to draw the bedside curtain but agree with the Board - and the Advisers, whom I discussed this with - that an alternative cannot reasonably always be arranged. The Advisers confirm that, medically, the information given to Ms C was correct. For example, one can know that a cancer will not be suitable for treatment without knowing its precise site/s. Ms C was also concerned that her mother was not treated on a cancer ward. The Advisers can reassure her by confirming that the Board's explanations to her about this (which I need not repeat here) were appropriate.

10. A CT scan on 20 October 2005 confirmed the presence of secondary cancer in the liver and a mass of something in the pancreas. Palliative care (essentially, care to alleviate symptoms without curing the illness) was planned, and a liver biopsy was arranged to establish the primary cancer site. In preparation for the biopsy, the anticoagulants (see paragraph 8) were stopped. Mrs A was – appropriately – allowed to leave the Hospital on 25 October 2005 to be with her family for a while. Meanwhile, the primary site was shown to be the pancreas, and chemotherapy was planned. This was because the Consultant felt that this might prolong Mrs A's life from two or three months to around six to nine months, although its outcome would be very dependent on whether Mrs A was responsive to chemotherapy and on the risk of further problems from the pulmonary embolus (see paragraph 8). On 26 October 2005, Mrs A became very short of breath, an ambulance was called to take her back to the Hospital, and, sadly, she died on that journey. The post mortem confirmed that death was due to pulmonary embolus and that there was a carcinoma of the pancreas.

11. In paragraph 10, I said that the anticoagulants were stopped so that the liver biopsy could be done. The Advisers confirm that this was appropriate. However, it meant that the pulmonary obstruction was no longer being cleared. As also indicated in paragraph 10, this was, in fact, the cause of Mrs A's death, not the terminal cancer. The Advisers confirm that the Board's explanation to Ms C about this was, medically, entirely appropriate. It is worth repeating the Board's explanation here:

'It is well known that patients with metastatic liver disease and underlying carcinoma do develop blood clots, and they can also have fatal pulmonary emboli as a result. It is a fine line between actually biopsying a sample of tissue such as the liver when the anticoagulant that is actually preventing the clots has to be stopped to allow the biopsy to proceed in a safe manner. If anticoagulant is recommenced too rapidly, there is a risk of bleeding from the site of the puncture; and if it is delayed too long, there is a risk of more clot formation.'

I also note the Consultant's comment (which the Advisers have confirmed as medically correct) in a letter to Mrs A's GP Practice in January 2006: he said that patients with an underlying malignancy can develop DVT and pulmonary emboli, both of which can be more fatal than the underlying disease. Sadly, that is what happened in Mrs A's case.

12. I have reported the Advisers' comments about the events of October 2005 throughout paragraphs 8 to 11. Here, I summarise their conclusions about that October admission:

'When admitted in October 2005, the correct diagnoses of DVT and pulmonary embolus were made, and appropriate treatment was given. It was only at this stage that abdominal investigations showed that Mrs A had not only a gallstone but also tumour/s - in the liver and probably in the pancreas. It was inevitable that her management was then going to be palliative, rather than curative. The decision to do a liver biopsy to confirm the primary site of the cancer was appropriate and that investigation was carried out appropriately.'

Conclusion

13. I have considered Ms C's complaints, the Board's response, the clinical evidence, and the advice (which I accept) from the Advisers. Ms C's concerns and worries were understandable as she had just lost her mother. But I hope that this report's explanations and comments, coming from the Ombudsman's office as an independent body, help to reassure her that her mother's care and treatment between July and October 2005 were appropriate and, in particular, that the cancer diagnosis could not have been made in July 2005. In all the circumstances, I do not uphold the complaint.

24 October 2007

Explanation of terms used

Ms C	The complainant
The Hospital	Aberdeen Royal Infirmary
Mrs A	Ms C's mother
The Advisers	The Ombudsman's clinical advisers
The Board	Grampian NHS Board
CT scan	Computed tomography scan
DVT	Deep vein thrombosis
The Consultant	A locum consultant physician at the Hospital

Glossary of terms

CLO test	Test to identify the presence of a particular bacterium
Computer tomography scan	A special radiographic technique that uses a computer to assimilate multiple x-ray images into a cross-sectional image
Pulmonary embolus	Blood clot causing obstruction in the lungs