Scottish Parliament Region: Highlands and Islands

Case 200701928: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; Clinical treatment/diagnosis

Overview

The complainant, Ms C, was concerned that, a few weeks after discharge from the Raigmore Hospital (the Hospital) following treatment for an obstructed gallbladder, her father, Mr A, was diagnosed with advanced pancreatic cancer. Sadly, Mr A died shortly after this diagnosis. In her complaint to the Ombudsman, Ms C was concerned that clinical staff at the Hospital had failed to detect this cancer and, in particular, questioned the quality of an ultrasound examination and why this was regarded as conclusive of Mr A's diagnosis despite contrary symptoms.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr A's ultrasound examination was not carried out with due care (*not upheld*); and

(b) in arriving at his diagnosis, Mr A's consultant did not take into account symptoms which conflicted with the ultrasound and, in particular, a CT scan should not have been cancelled (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. Sadly, Mr A, aged 72, died of advanced cancer of the pancreas on 12 January 2007. He had been diagnosed in late December 2006 following an emergency admission to a hospital in England.

2. Mr A had previously been admitted to Raigmore Hospital (the Hospital) in Inverness, following an emergency admission by his GP on 2 November 2006. Mr A's gallbladder was found to be obstructed and partially removed. Mr A was discharged on 6 November 2006. Mr A had gone to stay with his daughter, Ms C, in England following discharge and had been admitted to the hospital in England after becoming seriously unwell.

3. Following his death, Ms C sought further details about her late father's treatment and complained to Highland NHS Board (the Board) about the failure of clinical staff to diagnose the cancer during the admission in the Hospital. She remained dissatisfied after the Board's response and in October 2007 complained to the Ombudsman that she remained concerned about the following: the quality of an ultrasound scan on 3 November 2006, given that this had not revealed the presence of extensive cancer; that the results of this scan were accepted, although it was inconsistent with Mr A's symptoms; and a planned CT scan was cancelled.

4. The complaints from Ms C which I have investigated are that:

(a) Mr A's ultrasound examination was not carried out with due care; and

(b) in arriving at his diagnosis, Mr A's consultant did not take into account symptoms which conflicted with the ultrasound and, in particular, a CT scan should not have been cancelled.

Investigation

5. In investigating this complaint, I have obtained the background documentation relating to the complaint and Mr A's medical records from the Board. Advice was also obtained from a clinical adviser to the Ombudsman, (Adviser 1) and a consultant radiologist (Adviser 2). The abbreviations used in the report are set out in Annex 1 and medical terms are explained in Annex 2.

6. 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.

(a) Mr A's ultrasound examination was not carried out with due care

7. Mr A attended his GP on 2 November 2006, complaining of abdominal pain and several weeks of constipation. His GP referred him as an emergency to the Hospital. On admission, Mr A was noted to have a mass on the right side and a possible history of passing blood. An ultrasound scan was carried out on 3 November 2006, which showed a gallstone was obstructing the outflow from the gallbladder. This obstruction had caused the gallbladder to distend and was identified as the reason for the mass. The bulk of the gallbladder was removed on 4 November 2006, using a keyhole incision technique. A CT scan which had originally been booked for 4 November was cancelled. Mr A was discharged on 6 November 2006.

8. When Mr A was subsequently admitted to the hospital in England in December 2006, he was suffering from abdominal pain, jaundice, confusion and rectal bleeding. An ultrasound scan at that time showed evidence of extensive secondary cancer deposits in Mr A's liver, abdominal lymph nodes, spleen and lungs. A CT scan was performed and this showed advanced cancer of the pancreas. Given Mr A's condition, it was only possible for the Hospital to provide palliative care and, sadly, Mr A died on 12 January 2007.

9. Adviser 1 reviewed the clinical records held by the Board. He said that both the handwritten and typed report of the radiologist recorded the distended gallbladder and impacted gallstone. They indicated the liver, spleen and kidneys were normal but that other retroperitoneal tissues (this refers to the area behind the abdominal cavity) could not be seen at ultrasound. He said this would not be 'particularly unusual in normal people depending on technical circumstances'. Adviser 1 added that the detection of cancer in the liver depended on the detection of a localised change in the echo density. The changes caused by the early spread of cancer could be subtle and subjective.

10. Adviser 1 said he was aware that the opinion of the radiologist would be based on the scan in 'real time' and this could not be replicated. While doing the scan the radiologist would see the actual appearance of the liver and, in this case, he judged the liver to be normal. However, some representative images would have been taken and he advised that these be reviewed by a consultant

radiologist (Adviser 2). Adviser 2 was not informed of the subsequent diagnosis or of the details of the examination performed in 'real time' but was asked for general comments on the scans and, in particular, whether, from the images available, the liver parenchyma (this refers to the key elements of an organ essential to its functioning) was normal.

11. Adviser 2 reviewed 12 static images which had been recorded during the scan taken on 3 November 2006. He found these to be good quality images and technical factors such as focus had been correctly adjusted. The images were of both kidneys, the gallbladder and the spleen. Adviser 2 did not note any concerns about the organs in the images. He had been asked to particularly examine the liver scans and said there were limited available views of the liver but, from these, the liver appeared normal. In particular, he said there was no lesion present in the images of the liver he had received.

12. In his comments, Adviser 1 noted that Adviser 2 had only seen the representative images and that this did not indicate that the remaining liver was not examined, only that it was not recorded (see paragraph 10). Adviser 1 was not critical of the way the scan had been carried out and said there was no evidence that it had not been carried out with due care.

13. Adviser 1 concluded that, while there may have been early secondary cancers present at the time of scanning, the evidence from the scans was that they were not sufficiently advanced to be detectable on ultrasound examination. He noted widespread secondary cancers had been detected in the liver only some weeks following the images reviewed by Adviser 2 (see paragraph 8). He said that, while this was unusual, it was possible for certain rapidly aggressive cancers to proceed from an undetectable to a detectable size in such a short period of time. He also noted that the ultrasound evidence was consistent with the liver function tests which, with one exception, were normal. In his view, the enzyme which was noted as raised was very sensitive, particularly in the presence of gallbladder obstruction.

(a) Conclusion

14. Given the extensive nature of the cancer discovered in Mr A's second scan at the Hospital in December, I understand why Ms C has raised concerns about the adequacy of the scan on 3 November 2006. I hope that the advice I have received from Adviser 1 and Adviser 2, that the review of the scan indicates that the secondary cancers later detected in the liver area were not

advanced enough to be detected at this time, provides her with some reassurance on this point. Adviser 1 has not been critical of the way in which the ultrasound scan was carried out nor has he pointed to any evidence of undue care. Given this, and the advice I have received that the scan did not show evidence of cancer, I do not uphold this complaint. I will deal in more detail with the implications of this scan, in the light of Mr A's other symptoms, under heading (b).

(b) In arriving at his diagnosis, Mr A's consultant did not take into account symptoms which conflicted with the ultrasound and, in particular, a CT scan should not have been cancelled

15. Ms C has also said that she felt Mr A's symptoms were not fully explained by the ultrasound diagnosis. She said proper regard was not given, in particular, to the rectal bleeding and bowel function problems Mr A was experiencing and that the consultant responsible for his care should not have cancelled the CT scan. She felt that, as a result, Mr A had inappropriate surgery (partial removal of the gallbladder) which masked his symptoms and further delayed the diagnosis of cancer.

16. Adviser 1 considered Mr A's symptoms, as documented in the clinical record, in turn. He said that the position of the abdominal pain was entirely compatible with the diagnosis of gallbladder disease. Constipation was a non-specific symptom but, again, was compatible with gallbladder disease.

17. Adviser 1 agreed with Ms C that he would not regard rectal bleeding as a symptom of gallbladder disease and he considered all references to this in the clinical records. He noted that on admission this was given as a possible, rather than a definite, symptom. It was mentioned again in a ward round on 3 November 2006. However, there was no further record of this in the nursing notes and the haemoglobin level and size of red blood cells showed no sign of iron deficiency, which Adviser 1 said one would expect in significant rectal blood loss. Adviser 1 noted that minor rectal bleeding in the elderly was often associated with constipation.

18. Adviser 1 also considered Ms C argument that, given the symptom of rectal bleeding, the CT scan should not have been abandoned when it was revealed the mass identified on admission was caused by gallbladder disease. He understood Ms C concerns on this point, however, he said that, once the cause of the gallbladder disease had, in turn, been established by ultrasound:

> ‘it would not generally be considered good practice to submit a patient to both ultrasound and CT scan unless there was clear evidence of dual diagnosis. Moreover, the most appropriate investigation to identify the cause of rectal bleeding would be either a barium enema examination or colonoscopy not CT scanning.’

19. Adviser 1 noted that it was also relevant, in his view, that rectal bleeding was not diagnostic of either gallbladder disease or pancreatic cancer.

20. In his conclusion, Adviser 1 said that, sadly, it was clear with hindsight that Mr A had two diagnoses: an obstructed gallbladder and pancreatic cancer. While the cancer was likely present in November 2006, the evidence was that it was not detectable by ultrasound. The diagnosis of the obstructed gallbladder was, therefore, reasonable in the light of the ultrasound and largely compatible with Mr A’s symptoms. He said that, in the absence of any ‘objective evidence of a dual diagnosis’, the decision to recommend the gallbladder operation was reasonable.

(b) Conclusion

21. Clearly, Adviser 1 felt Ms C’s concerns were understandable, however, the advice I have received from Adviser 1, that the diagnosis and decisions made not to proceed to a CT scan and to operate, were reasonable I have not upheld this complaint. Adviser 1 felt that Ms C’s argument on this point was worthy of consideration and I would like to stress again that, given the rapid deterioration Mr A experienced, it was understandable she would wish these matters to be independently considered.

22. The Ombudsman has no recommendations to make.

Annex 1

Explanation of abbreviations used

Mr A	The aggrieved, Ms C's father
The Hospital	Raigmore Hospital, Inverness
Ms C	The complainant, Mr A's daughter
The Board	Highland NHS Board
Adviser 1	Clinical Adviser to the Ombudsman
Adviser 2	Consultant Radiologist

Annex 2

Glossary of terms

CT scan	Computerized tomography: pictures of structures within the body, created by a computer which takes the data from multiple x-ray images and turns them in pictures
Haemoglobin	The oxygen carrying pigment and dominant protein in red blood cells
Jaundice	Yellow staining of the skin, which can indicate liver or gallbladder disease
Lesion	An abnormality due to disease or injury
Palliative	The provision of care to provide comfort and, where possible, slow a condition which it is not possible to cure
Parenchyma	The key elements of an organ essential to its functioning
Retroperitoneal	The area behind the abdominal cavity
Ultrasound	A radiology technique, which uses high-frequency sound waves to produce images of the organs and structures of the body