Scottish Parliament Region: Glasgow

Case 200700891: Greater Glasgow and Clyde NHS Board [1]

Summary of Investigation

Category

Health: Clinical treatment/diagnosis

Overview

The complainant, Mr C, complained that treatment received by his late wife, Mrs C, was inadequate and that staff failed to diagnose that she was suffering from melanoma.

Specific complaint and conclusion

The complaint which has been investigated is that the treatment Mrs C received from 2004 was inadequate and staff failed to diagnose that Mrs C was suffering from melanoma *(partially upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review their procedures, in line with the findings of this report, for the carrying out of biopsies on patients diagnosed with cancer and having a similar history to that of Mrs C;

(ii) consider the findings of this report in relation to removing complaints from the NHS Complaints Procedure and consider subsequently reinstating

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde NHS Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde NHS Board.

them if dealing with future complaints resulting from similar circumstances; and

(iii) write to Mr C with an apology for the distress caused by the failings identified in this report.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. In 1987 Mrs C was referred to a dermatologist (Dermatologist 1), following the appearance of a mole on her right thigh. The mole was excised and subsequently found to be benign. There was no follow-up arranged. In 2004, Mrs C's then GP referred her to another dermatologist (Dermatologist 2) in the Royal Alexandra Hospital (the Hospital), after finding a small lump close to the scar of her original surgery. On clinical examination Dermatologist 2 considered the lump benign. Mrs C was reviewed some three months later and the senior house officer who saw her considered the lump was slightly smaller than it had been previously and discharged her. In February 2006 Mrs C was referred back to the Hospital and seen by a neurologist, suffering from spatial orientation problems and showing signs of clumsiness. At that time the physical signs were regarded as being insubstantial and she was discharged, pending a MRI scan. Before the scan took place, however, Mrs C's symptoms worsened and she presented to the Hospital's Accident and Emergency Department in February and March 2006. On the second occasion she was admitted to the Hospital and evidence of secondary cancer on her brain and chest was found. Investigations were carried out to determine the primary source of the cancer but this was not identified. Her condition deteriorated and, sadly, Mrs C died on 23 August 2006.

2. Mr C wrote to Greater Glasgow and Clyde NHS Board (the Board) on 18 October 2006 detailing the care offered to Mrs C from 2004 onwards and articulating his view that his wife was not offered the correct treatment. On receipt of his complaint the Board wrote to Mr C, indicating that they wished to consider the complaint outside their standard complaints procedure and instead instigate an internal review by a plastic surgeon (the Consultant).

3. The complaint from Mr C which I have investigated is that the treatment Mrs C received from June 2004 was inadequate and staff failed to diagnose that Mrs C was suffering from melanoma.

4. In making his complaint to the Ombudsman, Mr C also complained that Mrs C had been misdiagnosed at a London hospital in 1987. Having viewed Mrs C's clinical records, the Ombudsman's independent medical adviser (the Adviser) noted that Mrs C had been referred to Dermatologist 1 at the London hospital in 1987, following the appearance of a mole on her right thigh.

Dermatologist 1 believed it to be a melanoma and arranged for its urgent excision. Microscopic examination (histology) of the excised mole was, however, reported to be benign and consequently no follow-up was arranged. This aspect of Mr C's complaint is not within the jurisdiction of the Scottish Public Services Ombudsman, because the events being complained about occurred outwith Scotland, and was not considered in conducting this investigation. I explained to Mr C that this aspect of his complaint would have to be made direct to the appropriate NHS Trust in London.

Investigation

5. On receipt of Mr C's complaint a request was made to the Board for a copy of Mrs C's clinical records. As a result of this enquiry I obtained Mrs C's hospital and GP notes, investigations and the clinical and complaints correspondence relevant to her care. Advice was sought from the Adviser and a number of questions relating to the complaint were then asked of the Board in a letter on 15 January 2008. The Board responded on 18 February 2008 and their response was considered by the Adviser.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The treatment Mrs C received from 2004 was inadequate and staff failed to diagnose that she was suffering from melanoma

7. On 28 June 2004 Mrs C's GP referred Mrs C to the Hospital after she had developed a small lump, close to the scar from previous surgery to excise a mole in 1987. She was seen by Dermatologist 2, who considered the lump to be a benign dermatofibroma. A dermatofibroma is a firm swelling composed of blood vessels and dense fibrous tissue, usually caused by mild trauma such as an insect bite. Dermatologist 2 decided to observe the situation without treatment and review again in three months time.

8. Mrs C was reviewed three months later. On 6 October 2004 she was seen by a senior house officer, who considered the nodule to be slightly smaller and, in view of the apparent benign nature and lack of change, discharged Mrs C from the clinic.

9. On 14 February 2006 Mrs C was referred urgently to a neurologist with neurological symptoms of difficulties with spatial awareness and clumsiness. She was seen in an out-patient clinic on 24 February 2006 but the physical signs were insubstantial. Investigation by MRI scanning was arranged but, in the meantime, her symptoms worsened and Mrs C presented to Accident and Emergency on 28 February 2006 and 2 March 2006, by which time clear physical signs of neurological disease had developed.

10. Mrs C was admitted to the Hospital on 2 March 2006 and investigation by CT scanning revealed evidence of deposits of secondary cancer in her brain and chest. A programme of further investigations was undertaken to determine the primary source of the cancer but this was not identified.

11. In his advice the Adviser explained that normally, in circumstances where disseminated cancer is diagnosed, a biopsy is taken from one of the cancer deposits in order to establish precisely the type of cancer present. This is done because different types of cancer respond to different treatments. In Mrs C's case, the secondary cancers in the brain and chest were not accessible to biopsy. In such circumstances, investigations are often undertaken to establish the site of the primary cancer from which the cancer deposits arise, since this would provide similar information. The Adviser stated that there is clear evidence from Mrs C's medical records of a diligent search for the primary source of her cancer, although the Adviser states that there is no reference in the Hospital's medical or nursing record to Mrs C's thigh nodule being investigated. The GP records indicate two references to the thigh nodule during a home visit on 17 May 2006 and 28 July 2006 – some weeks after the cancer has been recognised. These records clearly indicate the concerns of Mr and Mrs C, that the nodule in her thigh was related to the cancer, but there is no record of any specific action being taken in this regard.

12. Mrs C's care was transferred to consultants in Oncology and also Palliative Care. After an initial response to symptomatic treatment, Mrs C's condition deteriorated and she died on 23 August 2006. In accordance with her wishes, the nodule on her right thigh was examined post mortem and found to be a secondary deposit of malignant melanoma.

13. As indicated in paragraph 2, following Mrs C's death, Mr C wrote to the Board on 18 October 2006 expressing his view that Mrs C was not offered appropriate treatment. The Board's Director of Acute Services (the Director)

wrote back to Mr C on 2 November 2006 stating that they wished to consider his letter outwith the standard NHS complaints procedure stating that they:

> '…would prefer that your enquiry be removed from the normal complaints process to allow us to undertake this review as thoroughly and completely as possible, without the restrictions of the usual complaints response times…'

14. Mr C indicated that he was content for the Board to take this course of action. As the letter of 18 October 2008 was a letter of complaint, it would normally have been dealt with under the standard NHS procedure. The Board, however, instigated an internal review of the events which occurred, carried out by a plastic surgeon at the hospital. The Adviser stated that the internal review was carried out by an appropriately qualified professional and that Mr C was provided with a copy of the case review. The case review concluded that the melanoma was not diagnosed in 2004 but stated that this was not surprising. The case review also stated that it was debateable whether the melanoma being diagnosed in 2004 would have changed the course of events that led to Mrs C's death in 2006. Having taken the complaint out of the NHS complaints procedure and on the conclusion of the case review, Mr C's complaint was not then reinstated into the formal complaints procedure. It appears that Mr C was not advised at this time of his right of recourse to the Ombudsman's office if he remained dissatisfied.

15. It is clear that the diagnosis of dermatofibroma made on 7 July 2004 by Dermatologist 2 was wrong. The Adviser noted that it is not unusual for a dermatofibroma to be misdiagnosed as melanoma because of its sometimes rapid growth and brown discolouration and that under these circumstances a misdiagnosis is understandable. In Mrs C's case, however, the misdiagnosis was the other way round and a melanoma was misdiagnosed as dermatofibroma.

16. The Adviser also questioned the July 2004 diagnosis of dermatofibroma being made on clinical grounds alone and noted that a simple aspiration cytology of the nodule or excision biopsy would have put the matter beyond doubt. I wrote to the Board on 15 January 2008 asking for their view on the point and received the Board's response on 21 February 2008.

17. The specific questions asked of the Board related to the Adviser's view that the clinicians responsible for Mrs C's care should have taken into account

that: the referral letter from the GP indicated that a melanoma had been removed in 1987 (the records in 1987 indicated the mole was benign); there was no documentation of the histology; it is a recognised albeit unusual feature of malignant melanoma that secondary spread may become obvious many years after excision of the primary site; while recording his feeling that 'this could well be reactive', the GP expressed a concern that it may not be benign; and tethering of the skin can be caused by inflammation, as in dermatofibroma, but is also a feature of malignancy.

18. The Board's response was that Dermatologist 2 carefully considered the possibility of malignancy. He considered that the term melanoma can be used loosely by patients and non-specialists. Dermatologist 2 felt that this might have been true of the GP's letter of referral of Mrs C for three reasons. Firstly, he stated that Mrs C told him that the lesion was benign. Secondly, the surgical scar was small and there had been no secondary surgery or skin grafting, as would commonly be the case with a melanoma and, thirdly, there had been no clinical follow-up.

19. The Board also stated that Dermatologist 2's clinical hypothesis was retrospectively supported by the 1987 pathology report and that dermatofibromata are common reactive nodules affecting leg skin, particularly in females and following insect bites. The Board noted that preceding mosquito bites were documented in Mrs C's clinical notes.

20. In response to the Adviser's comment on the diagnosis being solely reached on a clinical basis, the Board stated that it was not standard dermatological practice to obtain pathology from all dermatofibromata and that clinical diagnosis was acceptable normal practice. Having considered the Board's response to this question and the others detailed in paragraphs 18 to 20, the Adviser stated his view that, on balance, Dermatologist 2's actions and diagnosis was reasonable.

Conclusion

21. Paragraph 12 shows that the diagnosis of dermatofibromata in July 2004 was incorrect. Having considered Mrs C's clinical notes, made the enquiries of the Board detailed in paragraphs 16 and 17 and received their response as detailed in paragraphs 18 to 20, the Adviser stated that he accepts that biopsy of every clinically diagnosed dermatofibroma would not be an appropriate policy for a Board to follow. The Adviser indicated his view that, on balance and

taking into consideration the information provided by the Board, Dermatologist 2's actions and diagnosis were reasonable, despite the fact that the diagnosis ultimately turned out to be incorrect. His reasons for doing so were the absence of any definitive evidence that the lesion removed previously may have been malignant. This included considering Dermatologist 2's observations of the very limited extent of the previous surgery and the absence of long term follow-up. The other reason cited by the Adviser for reaching his conclusion was that he had been reassured by the Board that the senior house officer who reviewed Mrs C prior to her discharge was appropriately trained and experienced in the field.

22. Having accepted that Dermatologist 2's diagnosis and actions were reasonable the Adviser did, however, raise an additional question relating to the treatment and care of Mrs C once her cancer had been diagnosed in 2006. The Adviser noted that the investigations undertaken to establish the nature of the primary cancer would have been taken to obtain tissue that would inform treatment and it was his view that, given this clinical picture, and taking the previous history into account, it would have been appropriate to conduct a biopsy of the accessible nodule in Mrs C's thigh. The Adviser also felt that Mr and Mrs C's repeated stated concerns about the nature of the nodule after the diagnosis of cancer would have made biopsy an appropriate action for a patient-centred approach to care and, for these reasons, I partially uphold Mr C's complaint.

23. Paragraphs 13 to 14 also indicate the circumstances in which Mr C's complaint was removed from the NHS Complaints Procedure. A consequence of removing the complaint from the generic NHS process is that while Mr C received a copy of the case review into his wife's treatment, by not responding to his complaint under the NHS Complaints Procedure Mr C was not advised at this time of his right of recourse to the Ombudsman's office. Mr C has stated that he was subsequently advised of his right to do so by his Member of the Scottish Parliament. While the Board were entitled to remove the complaint from the NHS Complaints Procedure for the purpose of holding a case review, having done so they should have considered reinstating it in the NHS Complaints Procedure so that Mr C's complaint was appropriately responded to.

Recommendations

24. The Ombudsman recommends that the Board:

(i) review their procedures, in line with the findings of this report, for the carrying out of biopsies on patients diagnosed with cancer and having a similar history to that of Mrs C;

(ii) consider the findings of this report in relation to removing complaints from the NHS Complaints Procedure and consider subsequently reinstating them if dealing with future complaints resulting from similar circumstances; and

(iii) write to Mr C with an apology for the distress caused by the failings identified in this report.

25. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's late wife
The Hospital	The Royal Alexandra Hospital, Paisley
Dermatologist 1	Dermatologist in the London hospital
The GP	Mrs C's GP
Dermatologist 2	Dermatologist at the Hospital
Senior House Officer	Senior house officer at the Hospital
The Neurologist	Neurologist at the Hospital
The Consultant	Consultant plastic surgeon at the Hospital, who conducted the case review following Mrs C's death
The Adviser	The Ombudsman's medical adviser
The Director	Director of Acute Services

Annex 2

Glossary of terms

Benign	A condition which should not become life-threatening. In relation to tumours, benign means not cancerous
Biopsy	A test which involves taking a small sample of tissue from the body so it can be examined
Dermatofibroma	A firm swelling composed of blood vessels and fibrous tissue, usually caused by mild trauma such as an insect bite. Dermatofibroma is not a type of cancer
CT scanning	An advanced form of x-ray that creates detailed images of the inside of the body
Histology	The study of the cells performed by examining a thin slice of tissue under a microscope
Malignant	A severe and progressively worsening disease, particularly in relation to cancer
Melanoma	A cancer of the pigment cells of the skin
MRI Scan	A scan which uses strong magnetic field and radio waves to produce detailed pictures of the inside of the body
Neurological disease	A disease having to do with the nerves or the nervous system
Nodule	A term used often in dermatology to describe a lesion which can be felt as a bump under the skin