

Case 200801842: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; cancer - diagnosis

Overview

The aggrieved (Mrs A) raised a concern that her husband (Mr A)'s prostate cancer was not detected in 2003/2004 when he attended a number of hospital appointments. Mrs A considered both that the cancer could have been detected at that earlier stage and that it should have been detected then.

Specific complaint and conclusion

The complaint which has been investigated is that Greater Glasgow and Clyde NHS Board (the Board) failed to provide Mr A with all appropriate care and treatment in 2003/2004 and as a consequence missed an opportunity to secure an earlier diagnosis of prostate cancer (*upheld*).

Redress and recommendation

The Ombudsman recommends that the Board review the Urology Department protocol for the assessment and management of men with new lower urinary tract symptoms bearing this case in mind.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 6 October 2008 the Ombudsman received a complaint from an advocacy worker (Ms C) brought on behalf of the aggrieved (Mrs A). Mrs A complained that Greater Glasgow and Clyde NHS Board (the Board) had failed in their care and treatment of her late husband (Mr A) in 2003/2004 because they did not diagnose prostate cancer at that time when they could have and should have. Mr A was diagnosed with prostate cancer in 2007 and died in 2008. Mrs A complained to the Board on 8 June 2008 and received a written response on 3 September 2008.

2. The complaint from Ms C which I have investigated is that the Board failed to provide Mr A with all appropriate care and treatment in 2003/2004 and as a consequence missed an opportunity to secure an earlier diagnosis of prostate cancer.

Investigation

3. In investigating this complaint I have considered correspondence supplied by Ms C and the Board and Mr A's clinical records for the time period relevant to the complaint. I have sought and obtained the views of a medical adviser to the Ombudsman (Adviser 1) and a specialist external medical adviser to the Ombudsman (Adviser 2).

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, Mrs A and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board failed to provide Mr A with all appropriate care and treatment in 2003/2004 and as a consequence missed an opportunity to secure an earlier diagnosis of prostate cancer

Medical Background

5. Adviser 2 gave me the following information about prostate cancer. Carcinoma of the prostate is generally regarded as a relatively slow growing condition. There is little firm evidence on the life history but the approach to the origin, growth, and progression of prostate cancer reflects an intuitive feeling that the cancer begins in the prostate gland with a few cells becoming malignant. This tumour probably remains localised within the gland for many years. Ultimately, it breaches the gland (becomes locally advanced) extends

into the lymphatic system and spreads through blood circulation where it has a particular tendency to cause secondary bone cancer. Generally the time from detection of a locally advanced tumour to death is approximately six years. Patients where the cancer has spread to the bone have a life expectancy of approximately two years. The treatment for locally advanced cancer and secondary cancer can only be palliative although there are hormone treatments which can slow the progress – ultimately though the tumour becomes hormone insensitive and spreads. Before the tumour spreads, radical treatment with surgery or radiotherapy can eliminate the disease. Prostate cancer can be unpredictable and there are large variations in the progress patterns. Prostate problems can produce lower urinary tract symptoms classified as irritative (frequency and urgency) or obstructive (hesitancy, poor stream) or both. The majority of men in this situation will have benign prostatic enlargement compressing the bladder neck or irritating the base of the bladder. If, however, the symptoms are found to be caused mainly by prostate cancer, then the tumour is likely to be locally advanced at a minimum and already beyond 'cure'.

Background

6. Mr A attended his GP surgery in October 2003 complaining of kidney pain, this was linked to his spontaneously passing a kidney stone. At that time a urine test was performed which showed no abnormality. Although a trace of blood was detected this was caused by passing a kidney stone. Repeat tests two months later showed no abnormality.

7. On 27 January 2004, Mr A was referred to the Urology Department at the Royal Alexandra Hospital, Paisley by his GP. At this time Mr A was complaining of painful and frequent urination after high fluid intake and aspermia (no sperm). His GP had already arranged a midstream urine specimen test and an intravenous urogram both of which were reported as normal. Mr A was seen on 17 February 2004 by a consultant urologist (Consultant 1) who arranged a flexible cystoscopy, although the working diagnosis was of no abnormality and that at most a period of bladder retraining might be helpful. The cystoscopy was performed on 18 May 2004 by a consultant urologist (Consultant 2), who noted that all (including the prostate) was normal. Mr A was discharged with advice that the problems were related to an increased fluid intake and there was nothing to offer in terms of treatment.

8. In early 2007 Mr A had attended his GP, seeking treatment for back and left leg pain. Physiotherapy and pain relief medication were tried without

success. On 18 May 2007 his GP arranged blood tests including a serum PSA test (prostate-specific antigen test) whose results showed significantly higher than normal levels. On 4 June 2007 Mr A was referred back to the Urology Department as a matter of urgency and was reviewed on 11 June 2007 by a consultant urologist (Consultant 3) who reported to Mr A's GP that he physically examined Mr A and found evidence of prostate malignancy. He recommended various medications (including morphine for pain relief) and arranged a bone scan. The bone scan showed wide spread cancer in the bone (bone metastases) and a hip replacement operation was performed on 26 June 2007. Mr A then underwent treatment and monitoring at the regional cancer centre. However, his condition deteriorated further and sadly he died in early 2008.

Mrs A's concerns

9. Mrs A complained to the Board that Mr A had presented with a number of symptoms of prostate trouble in 2004 but despite this, he was not diagnosed with cancer until June 2007. Mrs A described his symptoms as on-going and developing between 2004 and 2007. Mrs A feared that Mr A's cancer was so widespread by 2007 that it must have been active when he first attended the Urology Department in 2004 and that had it been detected at an earlier stage more could have been done to prevent the spread of the cancer to the bone. Mrs A sought a full investigation into the circumstances of her husband's missed diagnosis.

The Board's response

10. Mrs A's concerns were reviewed by the Clinical Services Manager of the Urology Department who discussed the concerns with Consultant 1 and Consultant 3. The Board explained in their response that a number of investigations were carried out in 2004 and these were all normal. The Board noted that:

'... at that stage (2004) [Mr A] did not complain of any symptoms suggestive of what would be termed as bladder outflow symptoms and it would not have been standard practice to take a sample of blood from [Mr A] to test for prostate specific antigen (PSA) with the symptoms he was experiencing. As [Mr A]'s symptoms were manageable, so long as he avoided excess fluids, no further appointments were arranged for him.'
'[Consultant 1] and [Consultant 3] have indicated that given [Mr A]'s tumour was diagnosed by PSA testing and clinical examination in 2007, this may have given the impression to [Mrs A] that these tests should have been performed two and a half years earlier and therefore an earlier

diagnosis made. This is not the case, as prostate cancer is a largely asymptomatic disease and only presents symptomatically at an advanced stage. [Mr A]'s symptoms in 2004 appear to have been of an irritative bladder problem and did not directly relate to his prostate. As far as investigation is concerned, PSA testing is not something recommended as a screening test for prostate cancer and in the absence of clinical disease, it would not have been carried out routinely, particularly in a man of [Mr A]'s age.'

Adviser 2's view

11. Adviser 2 told me that in his view the relatively recent onset of lower urinary tract symptoms (in 2004) in a middle aged man should have given rise to a higher level of suspicion of disease, and in particular he considered that most urologists would have more concern for the symptom of dysuria (painful passage of urine) than seems evident in Mr A's case. He noted that although it was more likely that there was no sinister reason for the symptoms it was still necessary to consider the possibility of cancer as the cause of the symptoms. As to how this might be achieved, Adviser 2 told me that there were reasons why widespread PSA testing may not be used by the Board and this is an area where there is considerable discussion and disagreement as to the best way forward. However, Adviser 2 was critical that there was no evidence of any physical examination of a middle aged man presenting with lower urinary tract symptoms and told me that in his view the majority of urologists would regard a failure to undertake a rectal examination in 2004 as amounting to substandard care. Adviser 2 also noted that the compounding symptom of 'no sperm' was noted but the reasons for this were not fully explored as such a symptom developing recently and spontaneously is certainly unusual. Adviser 2 concluded that even the slightest suspicion should warrant standard non-invasive and relatively cheap investigations such as rectal examination and serum PSA testing.

12. Adviser 2 noted that by the time of Mr A's diagnosis in 2007, Mr A had widespread cancer. Because of the nature and spread of this cancer Adviser 2 considered that the underlying tumour would have been locally advanced since mid-2005 and would, therefore, have been present within the prostate for two or three years before that and would, therefore, have been present in 2004. However, Adviser 2 emphasised that while he considered it likely that the cancer was present in 2004 he also considered (in view of the extent of Mr A's cancer in 2007) that it would already have been sufficiently advanced in 2004

that any treatment offered then (radical surgery or radiotherapy) would still have lead to a spread of the disease three or four years after and that the outcome for Mr A would have been identical.

Conclusion

13. Adviser 2 has told me that in his view the symptoms which Mr A presented with in 2004 should have given rise to more extensive investigations, namely a physical examination and a serum PSA test. He considered that the failure to undertake a physical examination at that time amounted to sub-standard care and that in his view it is highly likely that such an examination in 2004 would have detected the cancer at an earlier stage. Again I must emphasise though that he does not believe this would have resulted in a better outcome. Based on the clinical advice of Adviser 2 I uphold this complaint.

Recommendation

The Ombudsman recommends that the Board review the Urology Department protocol for the assessment and management of men with new lower urinary tract symptoms bearing this case in mind.

14. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify him when the recommendation has been implemented.

Explanation of abbreviations used

Ms C	The advocacy worker who brought the complaint on behalf of the aggrieved
Mrs A	The aggrieved
The Board	Greater Glasgow and Clyde NHS Board
Mr A	Mrs A's late husband
Adviser 1	A medical adviser to the Ombudsman
Adviser 2	A medical adviser to the Ombudsman
Consultant 1	A consultant urologist
Consultant 2	A consultant urologist
Consultant 3	A consultant urologist

Glossary of terms

Aspermia	Producing no sperm
Bone metastases	Metastatic cancer is cancer that has spread from the part of the body where it started (called its primary site) to other parts of the body. When cells break away from a cancerous tumor, they can travel to other areas of the body through the bloodstream or through the lymph system. Most often, cancer cells that break off enter the bloodstream. From there they can end up in any organ or tissue or in the case of bone metastases – the bone
Carcinoma	Cancer
Cystoscopy	Flexible cystoscopy uses a narrow, flexible, tube-like telescopic camera, called a cystoscope. This is passed up the urethra and into the bladder
Serum PSA test	Prostate-specific antigen test - the amount of PSA present within the blood stream. A small amount of prostate gland-produced PSA will normally leak into the blood stream and if the prostate gland enlarges, the serum PSA level rises accordingly. An enlarged prostate gland is associated with prostate cancer due to the growth of a malignant tumor. The PSA test measures the serum PSA level
Urogram	An intravenous urogram examines the urinary system by using a special dye (contrast medium) that is injected into one of your veins.

The dye travels through the bloodstream and is removed by the kidneys and passed into the ureters and bladder. The dye helps to show up these organs more clearly on x-rays