Scottish Parliament Region: South of Scotland

Case 201101137: A Medical Practice in the Borders NHS Board area

Summary of Investigation

Category

Health: General Practice; clinical treatment; diagnosis

Overview

The complainant (Ms C) raised concerns about delays and failures in the care and treatment provided to Mr A when he attended a medical practice (the Practice) on a number of occasions between December 2010 and February 2011 due to bowel problems and, from 11 February 2011 onwards, pain in his groin. Mr A had an ultrasound and CT scan in March 2011. He was diagnosed with diverticular disease and had to undergo emergency surgery. He had an abscess drained, repairs to his bladder and a section of his bowel removed. He was discharged with a stoma bag.

Specific complaint and conclusion

The complaint which has been investigated is that there was an avoidable delay by the Practice's GPs in fully investigating and diagnosing Mr A's condition *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Practice:		*Completion date*
(i)	issue a written apology to Mr A for the delay in fully investigating and diagnosing his condition;	1 August 2012
(ii)	carry out a Significant Event Audit on this case;	18 September 2012
(iii)	carry out a review of a sample of case notes to assess the quality of the recording of examination findings; and	18 September 2012
(iv)	ensure that revision of common abdominal conditions, including diverticulitis, forms part of the Continuing Professional Development of all GPs involved in this case.	18 September 2012

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

Main Investigation Report

Introduction

1. The complainant (Ms C) raised concerns about delays and failures in the care and treatment provided to Mr A when he attended a medical practice (the Practice) on a number of occasions between December 2010 and February 2011 due to bowel problems and, from 11 February 2011 onwards, pain in his groin.

2. The complaint from Ms C that I have investigated is that there was an avoidable delay by the Practice's GPs in fully investigating and diagnosing Mr A's condition.

Investigation

3. Investigation of the complaint involved reviewing the Practice's medical records for Mr A. My complaints reviewer also obtained advice from a professional medical adviser (the Adviser).

4. 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 terms used in this report can be found at Annex 2. Ms C and the Practice were given an opportunity to comment on a draft of this report.

Complaint: There was an avoidable delay by the Practice's GPs in fully investigating and diagnosing Mr A's condition

5. Mr A had a history of Irritable Bowel Syndrome (IBS). He saw GPs from the Practice on several occasions between 29 December 2010 and 28 February 2011 due to bowel problems and, from 11 February 2011 onwards, pain in his groin. He was referred for an ultrasound scan, which he attended on 4 March 2011. A computerised tomography (CT) scan was also carried out on that date.

6. Mr A and his wife (Mrs A) have stated that within an hour of having the scans, he was being prepared for emergency surgery. He was diagnosed with diverticular disease. He had a perforated diverticular abscess, which had led to a psoas abscess as well as a colovesical fistula (a passageway between the colon and urinary bladder). Mr A had an abscess drained, repairs to his bladder and a section of his bowel removed. He was discharged from hospital on

17 March 2011 with a stoma bag. Mr A said he has been left traumatised by the events and he has suffered physical and mental distress. He considered that his surgery would have been less radical and his recovery more rapid and complete if the GPs had referred him for investigation sooner.

7. In their response to Ms C's complaint, the Practice said that it would be reasonably straightforward with hindsight to identify that the complications of the diverticular disease probably arose around the beginning of February 2011, when Mr A's left leg symptoms arose for the first time. They said that the first clue that the problem involved the bowel and the bladder was when the out-of-hours doctor saw Mr A on 26 February 2011. They stated that things rapidly progressed to the point when the scan on 4 March 2011 confirmed the findings and emergency surgery was indicated.

8. The Practice said that it was their opinion that there had been no failure of medical care and no significant delay in the diagnosis of Mr A's problems. They said that he was seen whenever required and all the doctors involved made their best efforts to assess the situation and deal with the problems they faced. They said that only with hindsight could it be seen that what was developing was a rare and unusual situation. They said that appropriate tests and investigations were instructed and ordered during the course of events. They stated that when it became clear what the problem might be, necessary action was taken. They said that they were sorry that Mr A suffered all these problems.

9. I asked the Adviser if the Practice should have carried out further investigations into Mr A's symptoms at an earlier stage. In his response, the Adviser said that he had noted from the complaints correspondence that Mr A had suffered from IBS for some years. The Adviser commented that it was striking that no record of abdominal or rectal examination is present in any of the records for the period 29 December 2010 to 28 February 2011. He said that a stool sample had been requested, presumably for culture, but it was reported as negative. The comment 'watch weight' was noted on 28 January 2011. The Practice have told us that Mr A's weight was recorded electronically on that date and this was one kilogram more that the previous recorded weight in 2008. They said that this was in the upper range of expected weight for a man of Mr A's height. Poor appetite was noted on 7 February 2011, but no other records of weight measurements were noted in the records.

10. On 17 February 2011, a GP noted that Mr A had pain in his left groin. The Adviser commented that although it was noted that the groin was examined, no examination of the abdomen was noted. An ultrasound scan was ordered to exclude a femoral hernia. The Adviser said that it was difficult to follow the logic of this assessment, as a femoral hernia causing such pain may be incarcerated (where a piece of the intestine is stuck in the opening) or strangulated (where the blood supply is interrupted). He said that both of these possibilities should prompt urgent surgical assessment. Four days later, another GP saw Mr A and described him as being in agony and 'hardly able to move'. The GP recorded that they would 'await scan' and 'review if symptoms persist or if concerned'. The Adviser said that no clear reason for the groin pain was found. In response to the draft report we sent them and Ms C, the Practice said that the records showed that the working diagnosis was of femoral nerve root entrapment / irritation. They also said that the alternative differential diagnosis of femoral hernia was considered and appropriate investigation arranged.

11. On Saturday, 26 February 2011, an out-of-hours doctor visited Mr A. The doctor recorded that Mr A had unusual symptoms and needed to be reviewed. Mr A was seen by a GP from the Practice on Monday, 28 February 2011. It was recorded that he had pneumaturia (passing air via the penis), which raised the possibility of colovesical fistula, but was 'currently well'. The GP decided to revise the ultrasound request to include a bladder scan.

12. The Adviser stated that it was his view that admission to hospital on 28 February 2011 would have been entirely reasonable and logical. He said that given the symptoms presented, he could see no rationale for the decision to wait several days for the scan results.

13. The Adviser said that it was four days later that the key diagnostic investigation, a CT scan, was undertaken. He said that the CT scan appeared to have been done by the radiology department rather than at the request of the GP. He said that the findings were extremely serious and warranted immediate action by the radiology and surgical teams.

14. The Adviser said that it was his view that the Practice should have investigated Mr A's symptoms more thoroughly. Mr A was aged 57 at that time. The Adviser said he would expect abdominal and rectal examination findings to have been recorded in a man in his fifties with chronic bowel symptoms and weight loss, even if a history of IBS was known. He said he had noted the

comments recorded at the home visit on 26 February 2011 that Mr A lost two stones in weight during this period and he had no reason to doubt this. He commented that IBS is not associated with significant weight loss. He said that blood tests might have shown the presence of an inflammatory process and alerted the GPs to a problem other than IBS.

15. The Adviser stated that it was a particular concern that Mr A's changing symptoms in February were not placed together in context. He said that by this time, Mr A had ongoing bowel symptoms, a feeling of incomplete evacuation, excess bowel gas, weight loss, loss of appetite, fever symptoms and left groin pain which made it difficult to stand straight. He commented that there is nothing recorded in the notes about consideration of referral for these symptoms or whether an acute admission was required.

16. The Adviser concluded that clinical examination, blood tests and early referral of Mr A would have all been reasonable and logical responses to the symptoms he presented with. He said that the notes were deficient, particularly the lack of examination findings. He said that there appeared to be an assumption that Mr A's symptoms were due to IBS despite increasing evidence to the contrary. He stated that even when evidence of a passageway between bowel and bladder was present, there was no discussion with surgical colleagues and an apparent lack of understanding of the potential seriousness of the situation. A decision was taken to await the ultrasound rather than to bring forward surgical assessment. He said that whilst it was true that Mr A suffered an unusual complication of diverticular disease, he had clear evidence of an abdominal problem.

17. I asked the Adviser if the Practice should have made a diagnosis at an earlier stage. In his response, he said that in his opinion the GPs should have identified the problem earlier. He said that the presence of leg pain and difficulty in extending the hip are recognised signs consistent with irritation of the psoas muscle. He said that this is a rare event in general practice, but is a recognised phenomenon. He stated that it was reasonable for a GP to be aware of this possibility.

18. The Adviser said that symptoms of pneumaturia are also rare. He said that they should be regarded as a sign of a fistula until proven otherwise. He commented that there is a real risk of ascending urinary tract infection given that bowel contents are present in the urinary tract. He said that the Practice

should have treated such a symptom seriously and should have obtained advice from a surgical colleague as a matter of urgency.

19. The Adviser commented that for these reasons, it was his view that the Practice should have reached the conclusion that there was evidence to suggest a significant illness. He said that the GPs should have taken steps so that this could have been further defined as a matter of urgency. He stated that the evidence became more compelling as the month progressed

Conclusion

20. I have carefully considered the Adviser's comments and have concluded that there was an avoidable delay in fully investigating and diagnosing Mr A's condition. There is little detail of examination findings in the notes in relation to the symptoms that Mr A was presenting with, especially after he reported the pain in his groin on 11 February 2011. In particular, there was no referral or discussion with secondary care clinical colleagues when he presented with pneumaturia on 28 February 2011. The advice I have received is that the Practice should have obtained advice from a surgical colleague as a matter of urgency and it was not reasonable for them to decide to wait for the results of a scan that was to be carried out four days later.

21. In view of the above, I uphold the complaint.

Recommendations

22. I recommend that the Practice:	*Completion date*
(i) issue a written apology to Mr A for the delay in fully investigating and diagnosing his condition;	1 August 2012
(ii) carry out a Significant Event Audit on this case;	18 September 2012
(iii) carry out a review of a case note sample to assess the quality of the recording of examination findings; and	18 September 2012
(iv) ensure that revision of common abdominal conditions, including diverticulitis, forms part of the Continuing Professional Development of all GPs involved in this case.	18 September 2012

23. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	The aggrieved
The Practice	Mr A's GP Practice
The Adviser	The Ombudsman's GP Adviser
IBS	Irritable Bowel Syndrome
CT	Computerised tomography
Mrs A	The aggrieved's wife

Annex 2

Glossary of terms

Colovesical fistula	A passageway between the colon and urinary bladder
Computerised tomography (CT) scan	A scan that uses x-rays and a computer to create detailed images of the inside of your body
Femoral hernia	A hernia where the swelling protrudes downwards through the femoral canal which is in the groin
Incarcerated femoral hernia	A femoral hernia where a piece of the intestine is stuck in the opening
Pneumaturia	Passing air via the penis
Psoas muscle	A muscle that runs from just below the rib cage to the top of the leg bone
Strangulated femoral hernia	A femoral hernia where the blood supply is interrupted