Scottish Parliament Region: Lothian

Case 201202271: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; cancer; diagnosis

Overview

The complainant (Mr C) attended the Ear, Nose and Throat (ENT) Department of the Royal Infirmary of Edinburgh (the Hospital) on numerous occasions following referral by his GP in June 2010. During this period his symptoms, which included bleeding from the throat, worsened. After each examination, he was discharged and re-referred to his GP. On 28 September 2011, he was diagnosed at the ENT Department with throat cancer (a right tonsil mass).

Specific complaint and conclusion

The complaint which has been investigated is that staff at the ENT Department failed to investigate Mr C's symptoms appropriately and this led to a delayed diagnosis of stage 2 cancer of the right tonsil (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:		*Completion date*
(i)	apologise to Mr C for the failings identified;	9 September 2013
(ii)	carry out a Serious Clinical Incident Review; and	23 September 2013
(iii)	review the procedure for GP referrals to ensure that where there have been repeated referrals this is taken into account by ENT clinicians when assessing and examining the patient.	23 September 2013

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

Main Investigation Report

Introduction

1. Mr C had been referred by his GP to the Ear Nose and Throat (ENT) Department at the Royal Infirmary of Edinburgh (the Hospital) on numerous occasions between September 2010 and August 2011 because he had been coughing up blood in his phlegm. On each occasion he had been discharged by the ENT Department and re-referred to his GP, but in September 2011 was diagnosed as having a throat cancer, specifically a right tonsil mass.

2. Mr C complained to Lothian NHS Board (the Board) in April 2012. He set out in detail his referrals to the ENT Department by a number of different doctors at his GP practice. He said that he felt he had not been listened to by doctors or nurses within the ENT Department and that an incorrect initial diagnosis had been followed without question until the mass in his throat became too big to be dismissed.

3. Mr C said that he first attended an appointment at the ENT Department with a registrar in the ENT Department (Doctor 1) on 23 September 2010. At the time he had felt that the blood that he was coughing up was coming from his throat. Mr C said that he felt strongly that Doctor 1 was focusing on his nasal passages, despite what Mr C was saying to him. Mr C said that he raised the possibility of cancer with Doctor 1, but was told that his symptoms did not correspond with those of throat cancer.

4. Mr C was concerned that due to his dyslexia, he had not explained himself clearly to Doctor 1. He, therefore, wrote to the consultant responsible for his care (Doctor 2) on 24 September 2010. In this letter he explained that his symptoms had been present for nine months, and that in particular he had been suffering from a sore throat for this period. Mr C's GP received a discharge letter from Doctor 1 sent on 24 September 2010, which advised that the examination of Mr C had shown nothing remarkable and that he was being discharged back into the GP's care.

5. Mr C said that his symptoms continued to worsen and that the prescribed nasal spray increased the bleeding and soreness in his throat. He continued to see his GP about his problems and was referred to the ENT Department again on 26 November 2010. Mr C attended his appointment on 7 February 2011 and was seen by a locum consultant (Doctor 3). Mr C was examined again and

Doctor 3 told him that he had congested nasal passages which appeared inflamed, and that these were likely to be the cause of the bleeding Mr C was experiencing. Mr C was told there were no polyps present and no abnormal swellings in his neck. He was prescribed Flixonase nasules, and told he would be reviewed in a few months time.

6. Mr C was reviewed on 29 June 2011 by a different locum consultant (Doctor 4). He was again diagnosed with nasal congestion. Mr C underwent a flexible endoscopy, which he was able to watch via closed circuit television. Mr C was told the results were unremarkable. Mr C questioned this, asking why he was continuing to suffer from so many sore throats and why he was still bleeding. He was told again that the problem lay in his inflamed nasal passages and discharged into the care of his GP.

7. On 9 August 2011 a locum GP made a referral to the ENT Department requesting a review for Mr C as his tonsils were visibly enlarged and more painful than ever. On 26 August 2011, Mr C's GP made an urgent referral to the ENT Department, due to a diagnosis of suspected cancer, as Mr C's neck was now visibly swollen. Mr C was seen on 5 September 2011 by a new consultant (Doctor 5) who organised urgent biopsies and a pandenoscopy. These were carried out and Mr C was diagnosed with throat cancer on 28 September 2011.

8. The Board responded to the complaint on 4 July 2012. Mr C remained unhappy with the Board's response and brought his complaint to me on 28 August 2012.

9. The complaint from Mr C which I have investigated is that staff at the ENT Department failed to investigate Mr C's symptoms appropriately and this led to a delayed diagnosis of stage 2 cancer of the right tonsil.

Investigation

10. As part of this investigation all the information provided by Mr C and the Board was given careful consideration. This included Mr C's clinical records, all the complaint correspondence, the Board's policies and SIGN 90 (Scottish Intercollegiate Guidelines Network 90) on the Diagnosis and management of head and neck cancer. My complaints reviewer also obtained independent clinical advice from an ENT Consultant (the Adviser).

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

Complaint: Staff at the ENT Department failed to investigate Mr C's symptoms appropriately and this led to a delayed diagnosis of stage 2 cancer of the right tonsil

12. In their response to the complaint sent on 4 July 2012 the Board said the Clinical Lead for the ENT Department and the Chief Nurse had investigated his complaint.

13. The letter set out the symptoms Mr C had presented with at his consultation on 23 September 2010. The Board noted that the records showed that Mr C had informed Doctor 1 that he felt much better and that over the previous few weeks he had not had so many problems with his throat. On examination Mr C's neck, oral cavity and ears were found to be unremarkable and a fibre optic laryngoscopy was performed, which showed a normal looking mouth and throat.

14. The Board acknowledged that a letter dated 24 September 2010 had been received by Doctor 2, but said that the symptoms he described in the letter of a dry and rasping throat had been considered by a respiratory registrar, when Mr C was reviewed by that department on 5 October 2010.

15. The Board then set out the findings from Mr C's appointment at the ENT Department on 7 February 2011, where he was reviewed by Doctor 3. The records showed Mr C was complaining of a blocked nose and a bleeding throat, with particular problems in the morning. The Board noted the findings of Mr C's examination and said that again no obvious causes for his symptoms were identified. Mr C was, therefore, prescribed Flixonase nasules, with a planned review in June 2011.

16. The Board said that when Mr C was next seen on 29 June 2011 by Doctor 4, his nasal congestion and descending catarrh were very much better. The Board noted that Mr C had been able to watch the flexible endoscopy of his throat, and commented that they believed he had found it reassuring. Doctor 4 considered the findings to be unremarkable, and discharged Mr C. The Board stated that had he had any concerns at all Doctor 4 would not have discharged Mr C, but would have carried out further investigations.

17. The Board noted that when Mr C attended the ENT Department on 5 September 2011 his complaint had changed. The Board said that upon review by Doctor 5, Mr C was complaining of a sore throat on the right hand side. The pain increased with swallowing and radiated to his ear. Mr C had also reported croakiness in his voice and a bad taste in his mouth. Upon examination Doctor 5 was concerned that Mr C had a tonsillar malignancy, and arranged for urgent investigation and biopsies.

18. The Board said that it was with deep regret that staff had informed Mr C that he was suffering from a right tonsil mass. The ENT team acknowledged that this was a rare type of tumour, and was very difficult to spot in its early stages. They said that mouth cancer often did not cause any noticeable symptoms, which they believed was demonstrated by Mr C's case.

19. My complaints reviewer took advice on the actions taken by doctors during the series of referrals attended by Mr C prior to the diagnosis of cancer. The Adviser said that cancer in the oropharynx (the region containing the tonsils and especially the back of the tongue) is difficult to diagnose. It is common for patients to present in the advanced stages of the disease, due to a failure to refer for specialist examination. The bleeding Mr C had described suggested ulceration, but this may well not have been visible. The cancerous tonsil would have increased in size and surface ulceration would have become more obvious. With each successive visit by Mr C, the chances of detection through observation alone would have increased.

20. The Adviser said that the records for Mr C's first consultation in September 2010 showed a very thorough examination. He, therefore, concluded that although the cancer was likely to have been present in the tonsil at this time, it would have been impossible to detect. The Adviser noted that the second consultation involved an examination of the larynx with a flexible endoscope, but not of the mouth. He further noted that at the consultation in June 2011 the examination by flexible endoscopy was confined to the larynx and would not have shown the tonsil area. Three months later in September 2011, the tumour on the tonsil was obvious.

21. The Adviser felt that the thoroughness of the first examination, together with Mr C's clinical history, meant that it was an appropriate decision to discharge him at this point. He said that the two further referrals from Mr C's

GP on their own should have raised concern regardless of the patient's symptoms. In addition the records did not show that the subsequent examinations of Mr C had included an inspection of his tonsils. It was possible that the tumour would still have been hidden at the second consultation, but as it was easily seen in September 2011, he concluded that a more thorough examination at the June 2011 consultation would have resulted in the tumour being identified.

22. The Adviser stated that ENT staff had wrongly attributed Mr C's symptoms to nasal disease and had not given sufficient weight to his continual complaint of throat pain. He described the examinations that Mr C had received to be of a varying standard. He felt that following three referrals for primary care, there had to be a case for examination of the patient under anaesthetic, as there were recognised sites where cancer was difficult to spot, requiring either a blind biopsy, or fingertip examination under anaesthetic.

23. The Adviser noted that although the cancer should have been diagnosed sooner, it would not have influenced the treatment that Mr C then received. He added that the evidence suggested that the cancer had been caught at an early stage, due to the persistence of Mr C's GPs, who had pursued diagnosis through repeated referrals. Although he said it should be acknowledged that diagnosis of tonsil cancer was never easy, the evidence suggested it could have been diagnosed earlier with better out-patient examination.

Conclusion

24. Mr C complained that he should have been diagnosed earlier and had clinicians listened to his description of his symptoms and carried out the appropriate examinations, this would have happened. He felt that doctors had been swayed by their preconceptions rather than taking into account what the patient was telling them. Whilst a patient's description of their symptoms is an important part of the diagnostic process, clearly it is not unreasonable for doctors to rely on their clinical judgement.

25. Given that this complaint is about the diagnostic decisions made by a series of different clinicians, I have given significant weight to the independent advice obtained. The Adviser said that it was appropriate for Mr C to have been discharged following his first consultation, given the thoroughness of his examination. With regard to the second consultation, the Adviser found that given the number of referrals, there should have been increased suspicion of

the symptoms and consideration given to examining the tonsils. The advice received states that by the third consultation, in June 2011, the cancer could have been identified had a better examination been carried out, and that this delayed the diagnosis. This led to an injustice for Mr C and meant that Mr C was not able to commence treatment for his cancer at the earliest opportunity.

26. I am concerned that had Mr C's GP Practice not been so persistent in pursuing his case his cancer could have been left undiagnosed until the prognosis for him was significantly worse. I am also concerned that the appropriate examination required to diagnose the cancer was not carried out, given that it was a simple one, involving careful examination of the mouth and tonsils with a tongue depressor.

27. Given the number of referrals, and the failure to carry out a simple examination on two separate occasions I uphold this complaint. I cannot now alter the delayed diagnosis for Mr C, however, in recognition of his distressing experience, I recommend that the Board apologise to Mr C for the failings identified in this report. I further recommend that the Board provide evidence that they have carried out a Serious Clinical Incident Review into the failure to diagnose Mr C timeously. Also, that the Board review their procedures for dealing with repeated GP referrals and the point at which these should trigger more extensive investigations of a patient's symptoms.

Recommendations

28. I recommend that the Board:		*Completion date*
(i)	apologise to Mr C for the failings identified;	9 September 2013
(ii)	carry out a Serious Clinical Incident Review; and	23 September 2013
(iii)	review the procedure for GP referrals to ensure that where there have been repeated referrals this is taken into account by ENT clinicians when assessing and examining the patient.	23 September 2013

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
GP	General Practitioner
ENT	Ear Nose and Throat
The Hospital	Royal Infirmary of Edinburgh
Doctor 1	registrar in the ENT Department at the Royal Infirmary of Edinburgh
Doctor 2	consultant in the ENT Department responsible for Mr C's care
Doctor 3	a locum consultant who reviewed Mr C on 7 February 2011 in the ENT Department at the Royal Infirmary of Edinburgh
Doctor 4	a locum consultant who reviewed Mr C on 29 June 2011
Doctor 5	consultant in the ENT Department at the Royal Infirmary of Edinburgh, who diagnosed Mr C's tonsil cancer.
SIGN	Scottish Intercollegiate Guidelines Network
The Adviser	independent medical adviser retained by the Parliamentary Health Service Ombudsman, who gave advice on this case

Annex 2

Glossary of terms

Consultant	senior doctor who has completed all specialist training and has been placed on the specialist register
Biopsy	medical procedure involving taking a small tissue sample so that in can be examined under a microscope
Blind biopsy	medical procedure involving taking a small tissue sample from an area which has no specific abnormalities
Flexible endoscopy	examination of the inside of the human body using an endoscope
Endoscope	an endoscope is a thin, long, flexible tube that has a light source and a video camera at one end. Images of the inside of your body are relayed to a television screen.
Flixonase	drug used to treat asthma, and inflammation of the throat
Nasal spray	delivery method for steroids to the nasal passages, used for the treatment of hay fever, allergies and inflammation
Oncology	branch of medicine specialising in the treatment of cancer
Oropharynx	the area of the mouth containing the back of the tongue and the tonsils
Pandenoscopy	examination of the voice box, gullet, mouth nose and tongue, usually carried out by a

	surgeon
Registrar	doctor with sufficient experience and qualifications to be placed upon the General Medical Council's specialist register
Respiratory medicine	department treating the diseases affecting the respiratory tract
Tonsil	mass of tissue at the back of the human throat

Annex 3

List of Consultations attended by Mr C

Date	Department	Outcome
23 September 2010	ENT	Discharged
5 October 2010	Respiratory Medicine	Discharged
7 February 2011	ENT	Discharged
29 June 2011	ENT	Discharged
5 September 2011	ENT	Referred to Oncology