# Delay in diagnosis of thoracic aortic aneurysm (07HDC07977, 28 May 2008)

*Public hospital ~ District health board ~ Thoracic aortic aneurysm ~ Emergency department ~ Radiology reporting ~ Staffing ~ Discharge summary ~ Triage times ~ Supervision ~ Rights 4(1), 4(5)*

A woman complained about the care provided to her 72-year-old mother, who presented to the emergency department at a public hospital on four occasions over a ten-day period. On each occasion, she presented with slightly different symptoms, and it was only on the fourth attendance that she was diagnosed with a thoracic aortic aneurysm. The aneurysm ruptured before the woman could be operated on, and she died in the emergency department.

It was held that the woman suffered from a rare condition that is notoriously difficult to diagnose. The fact that a difficult diagnosis is missed does not constitute negligence. Apart from some delays in being seen in the emergency department, the woman received good, well documented assessments by emergency department junior doctors and nurses. However, there were three unsatisfactory aspects of the care she received over the course of her four emergency department presentations over ten days: (1) senior emergency department medical staff missed the "red flag" of unexplained thoracic back pain and did not review her in person when she re-presented; (2) there was a delay in radiology reporting; and (3) no discharge summary was provided following the woman's attendances.

The individual failures may not have warranted a finding that the Code was breached. However, their cumulative effect was to result in suboptimal care. In these circumstances, the public hospital breached Right 4(1) by failing to provide care of an appropriate standard. The public hospital also breached Right 4(5) by failing to ensure co-operation amongst its clinical staff and services, and between secondary and primary care, to ensure quality and continuity of care.