Misdiagnosis of a non-viable pregnancy
15HDC01413, 22 June 2017

Radiology clinic ~ Radiologist ~ Sonographer ~ Pregnancy ~ Ultrasound ~ Right 4(1)

A woman became pregnant and attended an appointment at a radiology clinic with a sonographer. This was the sonographer's second day working at the clinic. The sonographer performed a transabdominal ultrasound scan and a colour Doppler scan. The sonographer was unable to detect a fetal heartbeat and documented that there was no obvious fetal heart, and that the colour Doppler scan had shown a flash of colour adjacent to the yolk sac. The sonographer did not offer the woman a transvaginal scan during this appointment.

After the woman left the department, a radiologist reported on the ultrasound scan from the sonographer's worksheet and images. This was the radiologist's first day undertaking clinical work at the clinic. The radiologist reviewed the images the sonographer had taken and the findings she had documented in her sonographer report, and recorded them in his radiology report. The radiologist documented that there was "no obvious fetal heartbeat seen" and "no evidence of viability".

The woman was informed of the results of the report and attended an appointment at a miscarriage clinic where she was given misoprostol to assist with miscarriage. The woman later consulted with a general practitioner at a medical centre with concerns that she was yet to have her menstrual cycle since her miscarriage. The general practitioner arranged for an urgent ultrasound.

The woman attended the radiology clinic for a transabdominal ultrasound scan. A radiologist documented that the woman had a viable pregnancy, and the fetus was at "approximately 17 weeks 3 days plus or minus 10 days" gestation.

Findings

It was held that the sonographer should have offered the woman a transvaginal scan at the time of her appointment. Adverse comment was made in relation to the sonographer's failure to do so.

With regard to the radiologist it was held that by failing to obtain a second sonographer opinion, or recommend that a transvaginal scan should be performed, or recommend that the woman's β-hCG levels should be monitored, or organise a review scan in one week's time, and by reporting that there was no fetal viability, the radiologist did not provide services to the woman with reasonable care and skill and, therefore, breached Right 4(1).

The radiology clinic had access to information regarding the radiologist's training, qualifications, work history, and references; however, it did not identify his inexperience in the area of obstetric ultrasound scans prior to allowing him to report on obstetric ultrasounds. In addition, the radiology clinic did not allow the sonographer sufficient time to familiarise herself with the department and protocols in place prior to giving her a full case load, and did not record which protocols were provided to her. Furthermore, the protocols in place at the radiology clinic were outdated and did not provide adequate guidance for clinicians. Accordingly, the radiology clinic did not provide services to the woman with reasonable care and skill, and breached Right 4(1).

Recommendations

It was recommended that the radiologist arrange for a clinical peer review of the standard of his radiology reporting on obstetric ultrasounds; undertake an audit of recent obstetric scans performed; and apologise to the woman. The Commissioner recommended that the radiology clinic audit compliance with changes it has made to its ultrasound protocols to include a requirement for transvaginal ultrasound scans to be performed when there is a question regarding fetal viability. The Commissioner also recommended that the radiology clinic use this case as an anonymised case study to educate staff.