Delayed diagnosis of testicular torsion (04HDC00463, 7 June 2005)

Registered nurse ~ Medical officer ~ Public hospital ~ District health board ~ After-hours treatment ~ Emergency admission ~ Abdominal pain ~ Testicular torsion ~ Differential diagnosis ~ Triage ~ Examination ~ Investigation ~ Communication ~ Referral ~ Timeliness ~ Standard of care ~ Documentation ~ Protocols ~ Systems ~ Vicarious liability ~ Rights 4(1), 4(2)

The family of a 15-year-old boy complained about the treatment provided by a medical officer and a registered nurse at a rural public hospital. The boy experienced intense pain in the right side of his abdomen. When pain relief had not resolved the pain, but the symptoms had worsened, the boy's mother sought medical advice by telephone. The ambulance service operator said that it sounded like testicular torsion and dispatched an ambulance. The attending ambulance officer examined the boy. His diagnosis of possible appendicitis/testicular torsion was communicated to the admitting nurse at the emergency department.

The nurse asked the boy about the level of pain, but did not examine his scrotal area, as she believed him to be embarrassed. She assigned the boy as triage level 4 (to be seen by a doctor within an hour) and telephoned the on-call doctor, who was sleeping on-site. The doctor says that the nurse did not tell him of the possibility of testicular torsion, and so he instructed her to settle the boy's pain with intravenous morphine and to continue monitoring him until the morning.

The following morning, the doctor did not have the ambulance records, and the nurse's notes did not mention testicular pain but said "testes ok". The doctor ordered further investigative procedures, but did not examine the groin area until the early afternoon, when the boy, who was about to be discharged, told his mother that he still had pain in his right testicle. The doctor found the right testicle to be swollen and tender, and instructed the boy's mother to drive the boy to the regional hospital, as he needed to get there urgently, and the doctor considered private transport to be quicker in the rural setting. Two hours later the boy arrived at the regional hospital. After further minor delays, the boy was examined and testicular torsion confirmed, but the testicle could not be saved.

It was held that although the nurse had examined the boy appropriately, she breached Right 4(1) by failing to call the doctor again when he had not seen the boy within the triage time. She also breached Right 4(2) by making incomplete records and failing to follow hospital policies for accepting verbal orders and administering medicine.

It was also held that the doctor's failure to examine the boy on his admission to hospital breached Right 4(1). On discovering the torsion, the doctor should have warned the parents that the delay already incurred might have caused irremedial damage, and contacted the regional hospital in advance to expedite treatment.

The DHB was held vicariously liable for the breaches, as it had allowed development of a culture where patients presenting overnight would wait until morning before being assessed and treated by a doctor, and it had not enforced its assessment and triage policies.