Misdiagnosis of pyogenic abscess as hydatid cyst (01HDC07116, 13 January 2004)

Surgical consultants ~ House surgeon ~ Registrars ~ Radiologist ~ General surgery ~ Communication ~ Misdiagnosis ~ Right 4(1)

An independent 76-year-old woman presented to her GP with a painful lump in her kidney region following a fall several days earlier. An ultrasound was performed and the patient referred to the surgical outpatient department for assessment. The patient presented to the Emergency Department 12 days later, her referral having been classified as non-urgent. She was admitted by the surgical house surgeon and seen by the consultant the next day. Provisional diagnoses included a hydatid cyst, myosarcoma or a secondary tumour. An abdominal CT scan was ordered that day, requesting "locate lump, suggest diagnosis".

The CT report noted that the lump was in keeping with the suggestion of a hydatid cyst. The radiologist later confirmed that his role was to report on what he saw, not to make a diagnosis. The CT report was not seen by the consultant, but relayed to him verbally by a member of his team. He formed the view that the CT had confirmed that the patient had a hydatid cyst.

Despite concerns raised by the patient's family, and documentation in her notes that she was considerably unwell, the consultant discharged her home two days after the scan. Following discharge she continued to deteriorate and the lump grew. She was readmitted one week later and placed under the care of a consultant colorectal and general surgeon, as the original consultant was on leave. The patient's condition continued to deteriorate and eventually, after the diagnosis was questioned, a decision was made to aspirate the lump. However, the aspiration was delayed because of a breakdown in communication as to when handover back to the original consultant was to occur. In the meantime, the patient's condition deteriorated significantly.

The aspiration obtained pus, and the patient was taken to theatre for drainage of the abscess. She was admitted to ICU, where she developed problems with the right side of her chest. She declined ventilation and died several days later.

The patient's niece complained that medical staff had misdiagnosed the patient with hydatids, and that she was inappropriately discharged from hospital when she was still ill.

It was held that the original surgical consultant was in breach of Right 4(1) of the Code. In making his decision, the Commissioner outlined the following points:

- With respect to the reporting of the CT scan, it was unwise for the consultant to uncritically accept the advice given to him by his team member — the consultant was unfamiliar with hydatid cysts, and this was an extremely unusual diagnosis. On receiving the information he should have discussed the matter further with the radiologist.
- There was insufficient clinical evidence to rely on the diagnosis of hydatids without entertaining other diagnoses.
- The consultant failed to ensure that his registrar spoke directly to the second consultant, rather than the second consultant's registrar. Had that communication occurred and the second consultant been made aware of the clinical situation, he would have questioned the diagnosis.

- Discharging the patient without a definitive diagnosis, and in the presence of abnormal test results and concern from staff and family that she was still very unwell, was a failure to exercise a reasonable standard of care.

Neither the colorectal and general surgical consultant nor the hospital was found to have breached the Code.