False positive reporting of prostate biopsy slides (08HDC07231, 28 April 2009)

Locum pathologist ~ Public hospital ~ District health board ~ Prostate biopsy ~ Cancer misdiagnosis ~ Prostatectomy ~ Unnecessary surgery ~ Vicarious liability ~ Right 4(1)

A 67-year-old man complained about the services provided by a locum pathologist at a public hospital. He was referred by his general practitioner to the public hospital's urology department owing to persistently raised levels of prostate specific antigen. During his initial review with a urologist the man requested further investigations, and an ultrasound and prostate biopsy were performed. The biopsy slides were reviewed by a locum pathologist, who worked for six days at the hospital. She reported carcinoma on the right side of the man's prostate. Special stains were not requested to verify her diagnosis, nor was a second opinion obtained from another pathologist. A multidisciplinary meeting was not held.

The urologist discussed the biopsy results with the man, who indicated a preference for surgery, and he subsequently underwent a radical prostatectomy. Although the procedure itself was uneventful, the man experienced ongoing urinary incontinence following surgery, requiring the use of several pads a day. The prostatectomy slides were reviewed by another pathologist, who did not detect any evidence of malignancy. Instead, the histology showed "extensive areas of gland atrophy". The man was informed of the findings, and a sentinel event investigation was carried out.

It was held that the locum pathologist breached Right 4(1) for lack of care in making the cancer diagnosis. Prior to reporting her findings, she did not order special stains (immunoperoxidase studies) to verify her diagnosis, nor did she seek a second opinion from a colleague.

It was also held that the DHB breached Right 4(1) as it did not have robust systems to detect incorrect pathology results. In addition, the DHB was held vicariously liable for the locum pathologist's breach as it did not take reasonable steps to reduce the risk of her error.

This case highlights the importance of the clinician carrying out checks to verify a diagnosis of prostate cancer. It also highlights the need for robust laboratory and hospital systems to support the work of the diagnostic clinician.