Follow-up of abnormal histology result
14HDC00988, 10 February 2017

District health board ~ Adenocarcinoid tumour ~ Abnormal histology results ~ Systems ~ Right 4(1)

In 2009, a woman presented to a public hospital with suspected appendicitis. She underwent an appendectomy performed by a general surgeon. The appendix was acutely inflamed, and it was removed. Histology from the appendix showed an adenocarcinoid tumour.

At the time, the district health board (DHB) had no system to review pathology results electronically, and no backup system. The histology result was acknowledged by a junior doctor. However it was not escalated to the general surgeon. No follow-up treatment was arranged, and neither the woman nor her general practitioner (GP) were informed of the result.

In 2012, the woman complained to her GP that she had lower abdominal pain, and her GP referred her to the public hospital. There, a different general surgeon reviewed the woman. He considered that her symptoms might be caused by gynaecological pathology, and referred her to the gynaecological team for review. The general surgeon did not review the 2009 result.

Approximately three months later, the woman saw the obstetrics and gynaecology registrar. He noted that the woman was experiencing painful menstruation, and later performed an MRI, which indicated that the woman had diffuse abnormality in the pelvis affecting multiple organs, and that while most of the changes could be explained by endometriosis, malignancy could not be excluded.

The woman's health continued to deteriorate. She developed vomiting and diarrhoea, was unable to eat, and was losing weight. She was reviewed by an obstetrician/gynaecologist (O&G) in the gynaecology clinic. A report following a CT scan of the woman's chest, abdomen and pelvis stated: "[S]uspicious for malignancy and atypical for endometriosis given the extent and bowel involvement." A gynaecological multidisciplinary meeting (MDM) recommended that the woman be referred to the gastrointestinal MDM.

The O&G requested a general surgery review of the woman. During the review, a registrar noted that previous histology of the woman's appendix had indicated that it was carcinoid (the missed 2009 result). There is no evidence that this was escalated to the O&G, and the O&G was not made aware of the finding.

The woman was discharged that day. The discharge summary did not mention the 2009 result, and the woman was not told about it. Neither did the discharge summary mention the CT report that recorded the likelihood of malignancy. However, a couple of days later a referral was made for a colonoscopy, which recorded the woman's carcinoid histology, and queried recurrence of this. Her case was discussed at a gastrointestinal MDM, and her 2009 result was noted at the meeting, as was the CT scan result. It was recognised that the woman would require

surgery, and it was decided that her case would be taken over by the surgical team. At this stage, no possible diagnoses other than endometriosis had been discussed with the woman.

The woman was seen in the general surgical outpatient clinic by another general surgeon, who reviewed the woman's notes and noted that in 2009 there had been an incidental finding of an adenocarcinoid tumour. This was the first time it was identified that the 2009 result had not been followed up. The general surgeon said that he did not tell the woman about the 2009 result at that appointment because more information was needed, as both ovarian cancer and adenocarcinoid tumour can result in a similar clinical picture.

A staging laparoscopy and peritoneal biopsy were carried out. The findings were of widespread metastases, but there is no record that these, or the 2009 result were discussed with the woman at this time. A few days later, the general surgeon received the formal pathology from the biopsy and the woman was informed of her prognosis. This was the first time anyone from the DHB had told the woman of the tumour identified in 2009.

By now, the woman's condition was such that she was unable to tolerate surgery. She was referred to palliative care, and sadly, died.

It was found that the DHB held primary responsibility for the pattern of errors in this case, which raised concerns about the systems in place during the period in which the woman received care. The DHB failed to ensure that appropriate systems were in place so that abnormal results were escalated appropriately, that missed results were identified promptly, and that errors were disclosed in a timely and appropriate manner. The failures resulted in a pattern of seriously suboptimal care and, accordingly, it was found that the DHB failed to provide services to the woman with reasonable care and skill and breached Right 4(1).

Adverse comment was made that the second general surgeon, having made additional findings that would warrant review of any previous pathology, did not do so, and that the third general surgeon did not inform the woman of the missed 2009 result when he became aware of this. Adverse comment was also made that the DHB was unable to identify the junior doctor who acknowledged the woman's 2009 result.

A number of recommendations were made, including that the DHB perform a randomised audit of patient records to assess the effectiveness of its Electronic Acknowledgement of Results system, perform an audit evaluating the current access to MRIs (in particular regarding timeframes), use an anonymised version of HDC's report as a basis for staff training, and provide a written apology to the woman's family for the failings identified in the report.