Delay in surgery
(13HDC01012, 15 June 2015)

District health board ~ Public hospital ~ Urologist ~ Delay in surgery ~ Communication ~ Right 4(1)

Over a period of eight months a woman was diagnosed with four urinary tract infections. Blood tests showed a reduction in the woman's renal function. The medical centre that the woman was attending arranged further investigations, including a blood test, mid-stream urine tests (which showed white and red blood cells but no bacterial growth (no infection)), and testing for an atypical organism (which was not detected).

The woman was reviewed again by a GP at the medical centre. The woman did not report any further dysuria (painful urination), but she had experienced three episodes of haematuria (blood in the urine) the previous week. The GP referred the woman to a urologist at a public hospital

The woman had a CT scan of her abdomen and pelvis which showed a large right-sided renal carcinoma with associated lymphadenopathy. The woman's CT scan result was discussed at a multidisciplinary team meeting and the plan was to proceed to palliative nephroureterectomy (the surgical removal of a kidney and its ureter) and regional lymph node dissection if staging interventions did not show further widespread metastatic disease. The woman then had a CT scan of her chest.

The woman and her daughter-in-law attended an appointment with a senior urology registrar. The senior urology registrar advised the woman's GP that she had booked the woman on the urgent list for the surgical removal of her kidney. The daughter-in-law understood from this consultation that the diseased kidney would be removed and that everything would be fine. She said that they did not discuss any postoperative treatment with the senior urology registrar, but were advised that they would do so after the operation.

The woman's surgery was incorrectly entered into the booking system as semi-urgent instead of urgent. From the date of the woman's consultation with the senior urology registrar and her referral for surgery, it was 78 days before the woman underwent surgery.

The woman's CT scan of her chest was reviewed by the urology team three days prior to her surgery. The woman had a chest X-ray eight days before surgery but did not have a further CT scan. The woman had surgery, but not all of the cancer was surgically resectable, and results of a CT scan showed evidence of disease progression and masses in her mediastinum. The woman underwent radiotherapy and chemotherapy. Her chemotherapy was discontinued and, sadly, she died.

It was held that the medical centre appropriately managed and investigated the woman's urinary symptoms.

The district health board breached Right 4(1) as it did not provide the woman with services with reasonable care and skill by failing to carry out the woman's surgery within a clinically appropriate timeframe, and for the failure of its staff to discuss and consider the woman's chest CT scan report adequately prior to surgery. Adverse comment was made about the district health board for the explanation given to the woman about her condition. Adverse comment was also made about the urologist for not performing a further staging CT chest scan prior to the woman's surgery.