Delay in diagnosing cervical cancer and referring for treatment (03HDC15479, 19 October 2005)

Gynaecologists ~ Public hospital ~ District health board ~ Cervical cancer ~ Follow-up care and review ~ Cervical smears ~ Diagnostic tests ~ Colposcopy referral ~ Timing of specialist and treatment referrals ~ Patient's right to be informed of probable diagnosis of cancer ~ Rights 4(1), 4(4), 6(1)

The husband of a 42-year-old woman complained about the care she received at a public hospital. The woman attended the hospital with severe pain in her right side, and a provisional diagnosis of appendicitis was made. An emergency laparotomy found a normal appendix, but an infection in her right Fallopian tube. The appendix was removed and a pelvic lavage performed. She was discharged five days later and given appointments for a repeat pelvic scan, and for a review at the gynaecology clinic.

The woman saw a gynaecologist at the clinic six weeks later. Her tests were reviewed and she was referred to her GP for management. No smear was taken. In the following months she experienced ongoing lower back pain and attended outpatient clinics at the hospital for three scans. She returned to her GP later that year with severe pain in right side and lower back, and heavy, irregular periods. Her GP referred her back to the hospital, and she was admitted for further tests. An ultrasound identified a possible cervical mass.

The doctor requested an urgent biopsy, but the specialist, another gynaecologist, said there was no urgency and an appointment was made for four weeks later. At this appointment, he told the woman that "things are not looking good", but that as the labs were closing down for Christmas, results would not be available until well into the New Year, and that she would receive an appointment when the results were available. Two months later her condition was reviewed and invasive squamous cell carcinoma of the cervix diagnosed.

Although the gynaecologist at the clinic reviewed the woman's histology test results from her appendectomy, no gynaecological examination or cervical smear was undertaken. Had this been done, the woman might have received appropriate care much earlier. The gynaecologist was held to have breached Right 4(1).

The second gynaecologist's failure to inform the woman of her probable diagnosis of cancer was held to be a breach of Right 6(1). In addition, his failure to arrange prompt follow-up of the cervical smear results was unacceptable. The woman needed an urgent colposcopy and/or an early referral to oncology services. No patient in this situation should be left to wait for four weeks. The gynaecologist's failure to arrange appropriate follow-up was a breach of Right 4(4).

It was held that the systems operating in the gynaecology department at the public hospital were inadequate to ensure appropriate quality and continuity of care. A succession of missed opportunities resulted in avoidable delays in diagnosis and treatment. The awareness of, and response to, cervical cancer on the part of medical staff appears to have been poor. The DHB was found in breach of Right 4(1).