SPSO decision report

Case: **201304086, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the care that her father (Mr A) received from the board. Mr A's optician referred him to the Princess Alexandra Eye Pavilion (the hospital) when he complained of failing sight in his left eye. He was referred to the stroke clinic to check for a possible mini-stroke, and was given medication to prevent blood clots. Ten days after his initial hospital referral, Mr A was referred by his optician again, having started to experience problems in his other eye. Upon examination, issues highlighted by the optician were not recorded by the hospital eye specialist and Mr A was advised to attend an appointment he already had scheduled around three weeks later. Mr A attended that appointment, but his vision had deteriorated further. Staff were concerned that Mr A might have giant cell arteritis (GCA: inflammation of the arteries, particularly around the temples) and prescribed steroids. A scan and biopsy (tissue sample) of an artery in his head were also ordered. The biopsy was inconclusive, and Mr A was continued on steroid treatment in line with a diagnosis of GCA.

We took independent advice from one of our medical advisers - a consultant ophthalmologist (a doctor who examines, diagnoses and treats diseases and injuries in and around the eye). Our adviser said that Mr A suffered from anterior ischaemic optic neuropathy (AION: loss of vision due to damage to the optic nerve through lack of blood supply). This can be either arteritic, or non-arteritic (either caused by inflammation of the artery walls or not), and there is no treatment for non-arteritic AION.

We found that Mr A did not display symptoms normally associated with GCA when he first attended the hospital, and that his referral to the stroke clinic was appropriate in the circumstances. When he returned to the hospital, he and his optician had clearly reported a deterioration in his condition, with new symptoms affecting his right eye. The eye specialist did not observe these, but we were critical that he did not seek a second, senior, opinion, given Mr A's recent history and the optician's comments. We took the view that this resulted in an unreasonable delay in Mr A receiving steroid treatment. Our adviser also said that GCA is normally diagnosed by biopsy, but in Mr A's case the sample was too small to provide a definitive diagnosis. It was, therefore, impossible to say whether or not he had GCA or non-arteritic AION. However, we took the view that had steroid treatment started sooner the sight in Mr A's right eye might have been preserved.

Recommendations

We recommended that the board:

- apologise to Mr A for the issues highlighted in our investigation;
- share our decision with the staff involved in Mr A's treatment; and
- conduct a review of Mr A's case with a view to identifying any points of learning.