Scottish Parliament Region: Central Scotland

Case 200503060: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Gynaecology

Overview

The complainant (Mrs C) raised concerns about a delay by doctors at Monklands Hospital (the Hospital) in diagnosing that she had cancer of the cervix and that she should have been referred to the Colposcopy Clinic sooner.

Specific complaint and conclusion

The complaint which has been investigated is that there was a delay by doctors at the Hospital in diagnosing that Mrs C was suffering from cancer of the cervix (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) provide Mrs C with an apology for the failings which have been identified in this report; and

(ii) share this report with Gynaecologist 1 and his staff and encourage them to reflect on its findings.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 27 February 2006 the Ombudsman received a complaint from Mrs C with concerns about a delay by doctors at Monklands Hospital (the Hospital) in diagnosing that she had cancer of the cervix and that she should have been referred to the Colposcopy Clinic sooner. Mrs C had complained to Lanarkshire NHS Board (the Board) and attended a meeting with clinicians but remained dissatisfied with their responses. Mrs C subsequently complained to the Ombudsman.

2. The complaint from Mrs C which I have investigated is that there was a delay by doctors at the Hospital in diagnosing that Mrs C was suffering from cancer of the cervix.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and the complaints correspondence from the Board. I made a written enquiry of the Board. I obtained advice from two of the Ombudsman's professional advisers who are both Consultant Gynaecologists (Adviser 1 and Adviser 2) on the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Medical background

5. Mrs C, who was forty years of age, was referred by her GP (the GP) to the Hospital on 18 March 2004 with a one year history of very mild post-coital bleeding and a recent episode of severe bleeding after intercourse which lasted 24 hours. Mrs C was seen at the Gynaecology Outpatient Clinic (the Clinic) on 25 May 2004 where the Consultant Gynaecologist (Gynaecologist 1) noted Mrs C had had a cervical smear in 2004 which was reported as normal and that Mrs C was greater than 20 stone in weight. Gynaecologist 1 recorded the presence of a vaginal discharge and that the cervix bled on contact. A swab was taken and Mrs C was seen again at the Clinic on 1 June 2004 when Flagyl and Canesten were prescribed for thrush. Gynaecologist 1 saw Mrs C again on

15 June 2004 and performed a Cryotherapy procedure. Mrs C attended the Clinic on 3 August 2004 and was seen by a Senior House Officer (SHO) who noted Mrs C had most recently had no post-coital bleeding after intercourse or any sign of an abnormal vaginal discharge. Mrs C was discharged from the Clinic without being examined.

6. The GP referred Mrs C back to the Clinic where she was seen on 7 September 2004 and it was noted she had post-coital bleeding for one month which was now quite heavy although there was no vaginal discharge or pain. Mrs C received more Cryotherapy and was discharged only to be reviewed if she had further problems. The GP referred Mrs C back to the Clinic on 26 May 2005 (Note – the referral was marked Routine but graded Soon by a consultant gynaecologist who reviewed the referral) as the post-coital bleeding had returned as well as bleeding as soon as intercourse commenced and pain was being reported. Mrs C saw another Gynaecologist (Gynaecologist 2) on 20 June 2005 who was unable to visualise (view the outline of) her cervix and arranged for her to undergo Colposcopy. Mrs C attended the Colposcopy Clinic on 16 August 2005 where it was recorded that she now had intermenstrual bleeding as well as post-coital bleeding and that her periods were heavy and clots were present. On examination, Mrs C's cervix was found to be friable (brittle) and appeared malignant. Biopsies were taken which revealed a moderately differentiated adenocarcinoma. Mrs C was referred for chemotherapy and radiotherapy treatment as she was too overweight for surgery.

Complaint: There was a delay by doctors at the Hospital in diagnosing that Mrs C was suffering from cancer of the cervix

7. Mrs C complained to the Board that when she attended the Clinic on 3 August 2004 she told the SHO that she had only had intercourse once since the first Cryotherapy treatment which he said would settle but if not she had to return to the GP. After the second course of Cryotherapy Mrs C said she was told by the Hospital that if it did not work she would either have to return for more Cryotherapy or ignore the bleeding as it would not do her harm. However, the bleeding continued and worsened and this led to her treatment at the Colposcopy Clinic where the cancer of the cervix was identified. Mrs C wanted to know how the smear taken in 2004 could be reported as being normal; why, despite the symptoms, had doctors ruled out cancer of the cervix without a proper examination; and why did it take 18 months to refer her to the Colposcopy Clinic.

8. The Hospital General Manager (the Manager) responded that it was felt Mrs C had received appropriate treatment in 2004. Her smear had proved negative; a vaginal infection was diagnosed and treated; and Cryotherapy was performed. When the further referral was made in 2005, Gynaecologist 2 referred Mrs C to the Colposcopy Clinic as she could not examine her cervix satisfactorily. The biopsies confirmed a moderately differentiated adenocarcinoma which is a less common type of cervical cancer, develops in the inner lining of the cervix, and is not always present in cervical smears. The Manager said a review of smears taken in 1998 and 2001 were negative but both lacked cells from the inner lining. The 2004 smear had very few inner lining cells which appeared unremarkable under normal screening magnification. However, on closer examination and with the benefit of hindsight it was possible to identify minor changes in some of the groups but nothing to suggest cancer.

9. Adviser 1 reviewed the clinical records and papers and said that adenocarcinoma of the cervix arises from the glandular cells of the cervix and the cells are usually beyond the range of vision or beneath the surface. Cervical smears are not designed to detect adenocarcinoma which is confirmed by biopsy. Adviser 1 could fully understand why the cervical smear taken in 2004 was reported as normal as glandular changes are only found by chance.

10. Adviser 1 said it was perfectly possible that Mrs C did not have an invasive lesion in 2004 and that there was no visible abnormality. However, Adviser 1 felt that with Mrs C's returning symptoms and history of severe bleeding referral for Colposcopy at the time of her second Cryotherapy in September 2004 (paragraph 6 refers) should have been considered although it might not have detected the underlying carcinoma. Adviser 1 commented that as Mrs C was 20 stone in weight, clinicians found it hard to visualise her cervix in out-patients and combined with her symptoms, this made a colposcopic evaluation imperative. Adviser 1 said Mrs C was appropriately referred for Colposcopy in June 2005 when Gynaecologist 2 was unable to visualise her cervix.

11. In response to my request for information, the Board's Director of Acute Services (the Director) responded that Mrs C was seen by doctors in August and September 2004 who had Colposcopy experience and at that time there was no indication that this treatment was required. The Director said that the purpose of the Colposcopy Clinic is to evaluate patients with abnormal smears.

The smear taken in 2004 was reported as being normal and, therefore, Colposcopy examination would not have been appropriate. The Director added that even if Colposcopic examination had taken place then, i.e. one year before the finding of an early adenocarcinoma, then it was possible that no abnormality would have been detected.

12. Adviser 1 noted that there was no evidence that Gynaecologist 1 had investigated or reached a diagnosis of the cause of Mrs C's post-coital bleeding. The Adviser said that the cause of bleeding above the portio-vaginalis (external surface of the cervix) in the cervical canal or from the cavity of the womb should have been thought of and eliminated by either an endocervical smear; endocervical curettage; cervicoscopy and hysteroscopy; or a biopsy from the lining of the womb. Adviser 1 also felt there was a reason to Colposcope Mrs C as this would have been the only way to obtain an acceptable view of the cervix. Adviser 1 wondered why, if Mrs C's cervix was reported as normal, was there a need for Cryotherapy.

13. Adviser 1 noted that when Mrs C attended for the second Cryotherapy treatment it was recorded there was an observation of contact bleeding. He felt this was a further chance for staff to review the possible causes of the bleeding once more including the failure of the first Cryotherapy treatment and to try and achieve a diagnosis prior to further ablative (surgical excision) treatment. Adviser 1 considered that staff showed no sense of urgency or anxiety about a diagnosis in face of recurring and additional symptoms after two attempts to obtain a cure for an undiagnosed problem.

14. In summarising the treatment Mrs C received, Adviser 2 said that it was reasonable for staff to have carried out Cryotherapy in June 2004 (paragraph 5 refers) because of the recent negative smear and the lack of endocervical Chlamydial infection to cause the bleeding. However, since the symptoms did not respond then further investigations should have been carried out in September 2004 (paragraph 6 refers) to establish a diagnosis rather than repeat Cryotherapy. Adviser 2 felt the sensible route would have been Colposcopy with an endocervical sample, if the ecto-cervix was normal, and possibly even an endometrial biopsy. Adviser 2 commented that it would also have been appropriate to arrange a repeat smear at this time rather than repeat the Cryotherapy without further investigations.

Conclusion

15. Mrs C was referred by the GP to the Hospital for an opinion for the cause of post-coital bleeding. She was seen under the care of Gynaecologist 1 at the Clinic in May 2004, June 2004 and August 2004, during which she received an episode of Cryotherapy treatment before being discharged from the Clinic. A further treatment of Cryotherapy was performed by a Registrar in Gynaecology on 7 September 2004 following another referral from the GP due to heavy post-coital bleeding. The GP again referred Mrs C back to the Clinic as she was showing similar symptoms on 26 May 2005 where she saw Gynaecologist 2 who arranged for her to undergo Colposcopy treatment. The matter under consideration is whether Mrs C should have been referred to the Colposcopy Clinic at an earlier stage of her treatment.

16. The advice which I have received and accept is that it was appropriate for Gynaecologist 1 to perform Cryotherapy treatment in June 2004 in view of the recent negative smear result. However, when Mrs C was again referred by the GP in September 2004, it was at this time that Gynaecologist 1's staff should have considered Mrs C for Colposcopy treatment. The reason for this was because of Mrs C's returning symptoms and history of severe bleeding which required further investigation. It did not appear that Gynaecologist 1's staff took reasonable steps to reach a diagnosis for Mrs C's problems and were content to leave matters as being settled following Cryotherapy treatment. On the basis of the advice which has been presented I have decided to uphold the complaint that Colposcopy treatment should have been considered in September 2004 rather than following the further referral in May 2005. I have to point out, however, that even if Colposcopy treatment had been carried out in September 2004 it is possible that the carcinoma would not have been present or would not have been identified.

Recommendation

17. The Ombudsman recommends that the Board provide Mrs C with an apology for the failings which have been identified in this report. She also recommends that the Board share the report with Gynaecologist 1 and his staff and encourage them to reflect on its findings.

18. The Board have accepted the recommendations and will act on them accordingly.

18 July 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Hospital	Monklands Hospital
The Board	Lanarkshire NHS Board
Adviser 1	Ombudsman's professional adviser (Consultant gynaecologist)
Adviser 2	Ombudsman's professional adviser (Consultant gynaecologist)
The GP	Mrs C's GP
The Clinic	Gynaecology Clinic
Gynaecologist 1	Consultant Gynaecologist who saw Mrs C on 25 May 2004
SHO	Senior House Officer
Gynaecologist 2	Consultant Gynaecologist who saw Mrs C on 20 June 2005
The Manager	The Hospital General Manager
The Director	The Board's Director of Acute Services

Annex 2

Glossary of terms

Adenocarcinoma	A malignant tumour which begins in glandular tissue
Canesten	Medication for fungal infections
Cervicoscopy	Screening test for cervical cancer
Colposcopy	Visual examination of the cervix and vagina using a lighted magnifying instrument (colposcope)
Cryotherapy	Treatment using extreme cold temperatures to treat a disease
Endocervical Curettage	The removal of tissue from the inside of the cervix using a spoon-shaped instrument (curette)
Endocervical Smear	A smear obtained from the endocervical canal
Flagyl	Antibiotic to treat infection
Hysteroscopy	Diagnostic procedure in which a lighted scope (hysteroscope) is inserted through the cervix into the uterus to enable to the physician to view the inside of the uterus
Portio-vaginalis	External surface of the cervix
Thrush	Fungal infection of the vagina