Scottish Parliament Region: Central Scotland

Case 200701982: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised concerns about the treatment he received at Monklands Hospital (the Hospital), which resulted in the removal of his right kidney. Mr C had been told by staff that it was suspected a lump on his right kidney was cancerous and that removal of the kidney was required. Following the operation, Mr C was advised by staff that the removed kidney was non-cancerous. Mr C had concerns that staff took the decision to remove the kidney without taking a biopsy of the lump and the manner in which he was informed of the pathology of the removed kidney.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff acted unreasonably in removing Mr C's kidney before a definitive diagnosis had been made on the suspected cancerous lump (*not upheld*); and

(b) the manner in which Mr C was informed of the result of the pathology report of his removed kidney was insensitive (*upheld*).

Redress and recommendations

The Ombudsman recommends that Lanarkshire NHS Board (the Board):

(i) reflect on the Adviser's comments in relation to the way in which the consent was documented and consider whether they need to make any changes to procedure; and

(ii) make Mr C a further full and meaningful apology.

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

Main Investigation Report

Introduction

1. On 29 October 2007 the Ombudsman received a complaint from Mr C (through an advice caseworker) about the treatment he received at Monklands (the Hospital), which resulted in the removal of his right kidney. Mr C had been told by staff that it was suspected a lump on his right kidney was cancerous and that removal of the kidney was required. Following the operation, Mr C was advised by staff that the removed kidney was non-cancerous. Mr C had concerns that staff took the decision to remove the kidney without taking a biopsy of the lump and the manner in which he was informed of the pathology report on the removed kidney. Mr C had complained to Lanarkshire NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaints from Mr C which I have investigated are that:

(a) staff acted unreasonably in removing Mr C's kidney before a definitive diagnosis had been made on the suspected cancerous lump; and

(b) the manner in which Mr C was informed of the result of the pathology report on his removed kidney was insensitive.

Investigation

3. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser), who is a consultant nephrologist regarding the clinical aspects of the complaint. I made a written enquiry of the Board.

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 in Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Staff acted unreasonably in removing Mr C's kidney before a definitive diagnosis had been made on the suspected cancerous lump and (b) The manner in which Mr C was informed of the result of the pathology report on his removed kidney was insensitive

5. Mr C complained to the Board on 26 June 2007 about the treatment he had received at the Hospital. He had been under the care of a consultant nephrologist (Consultant 1) and a consultant urologist (Consultant 2) and he had suffered from kidney trouble for some time. However, after a scan, Mr C said he was told that a lump on his right kidney was cancerous and there may be a tumour behind it. On this advice, Mr C had his right kidney removed on 12 April 2007. Since the removal of the kidney, Mr C has had to undergo kidney dialysis three times a week and it has had a major impact on his everyday life. Mr C said he subsequently received a letter, dated 15 May 2007, from Consultant 2 stating that the tests which were carried out on his removed kidney proved to be non-cancerous and that it was hoped that he was doing well. Mr C was astounded because his life had changed beyond all recognition and yet nobody from the Hospital had telephoned him to arrange an appointment to discuss the findings. Mr C wanted the Board to investigate why a biopsy was not taken to confirm the suspicions of cancer which resulted in the removal of the kidney when both kidneys may have continued to support him for some years. He also wanted to know why he had to receive the devastating news that the removed kidney was non-cancerous in such an offhand letter.

6. The Board's Interim General Manager for the Surgical and Critical Care Clinical Division (the Manager) responded to Mr C on 26 July 2007. She explained that Mr C had been under the care of Consultant 1 with progressive nephropathy. During the course of investigations, and after an ultrasound scan and a CT scan, a large lump was found within Mr C's right kidney and there was swelling of the lymph nodes behind the vena cava. The Consultant Radiologist (Consultant 3) who reported on the films felt that this indicated a tumour within the kidney, with swelling of the glands. Mr C was referred to a Consultant Urologist (Consultant 4) who took the films to the Urology multi-disciplinary team meeting for review. The unanimous consensus of the group, which included other urological surgeons and a urology cancer specialist, was that the lump was a tumour and that Mr C would benefit from surgery. Consultant 2 had advised that renal cancer is a type of cancer which does not respond to chemotherapy or radiotherapy and that surgery was the only real potential curative option. The Manager continued that it would not be normal practice when a lump on a kidney had the classic appearance of renal carcinoma to

perform a biopsy. The reason for that was that there is a significant false negative rate due to the heterogeneous (varying) nature of the tumour. Even if a biopsy had been performed and proved to be benign, it would be extremely likely that the advice of any surgeon would be to proceed with surgery, on the basis that the result is likely to be a false negative. In addition, there is a significant risk that if the lump was cancerous and a biopsy was taken that cancer cells could feed along the biopsy tract.

7. The Manager said that Consultant 1 and Consultant 2 took the opportunity to speak to Mr C at the renal clinic at the Hospital. The reasons for not performing a biopsy were explained to Mr C and he was told that occasionally these types of lumps do turn out to be benign, although even under the circumstances the appearance on the CT scan was so abnormal that it was felt the kidney should be removed. Mr C was also told that the lump was more likely to be malignant and the risks of surgery were explained to him. Consultant 2 also took the opportunity to speak to Mr C again in the presence of his family. The risks were again discussed, with an emphasis on Mr C's progressive kidney disease and Mr C subsequently gave consent to surgery.

8. The Manager explained that Mr C had a progressive chronic kidney disease and was in a significant degree of renal failure at the time the lump was discovered. Consultant 2 had said that it was almost inevitable that Mr C was going to be rendered dialysis dependent by the nephrectomy and this was explained prior to surgery. The Manager continued that Mr C did not require dialysis immediately as the surgery was on 12 April 2007 and dialysis started on 26 May 2007. There was no doubt that the nephrectomy hastened the need for haemodialysis but Consultant 1 had anticipated that Mr C would have been on haemodialysis by the end of the year at the latest, given the severity of the kidney disease.

9. The Manager said that Consultant 2 acknowledged that, following the nephrectomy, it took some time for the histology to be formally reported. This was due to the extremely bizarre and abnormal appearance of the kidney. The pathologist was aware of the urgency of reporting the results but wanted to be precise in its reporting. After the report on the removed kidney was received, the histology and the radiology results were reviewed at a urology multi-disciplinary team meeting again with the pathologist, a cancer specialist and Consultant 2's colleagues. Even with hindsight, it was still unanimously believed by the group that removal of the kidney had been the correct action to

take. However, by then, some time had elapsed and Consultant 2 acknowledged that it is always difficult to know how a patient will feel about such news. As Mr C was then attending the Hospital for further treatment several times a week, it was felt that the quickest and least inconvenient way of contacting him with the result was by letter. Consultant 2 felt that the histology although it turned out to be benign, if completely abnormal, was good news and the letter was very positive. The Manager offered her sincere apologies if Mr C felt that receiving the results in such a manner caused additional distress. The Manager understood Mr C had an out-patient clinic appointment to see Consultant 2 in August 2007 and that he would be happy to discuss any outstanding concerns at that time.

10. The Adviser told me that Mr C had a past medical history of chronic kidney failure. It was clear from the records that Mr C's kidney function was at a very low level in the period January to March 2007 (13 percent of normal function). In December 2006, Mr C developed lower urinary tract symptoms and a kidney ultrasound scan showed a mass in the right kidney. It was noted that a previous ultrasound scan taken in 2001 had shown no evidence of a mass. On 15 January 2007, a CT scan of the abdomen was performed. The reported findings were that there was a 6.3 centimetre irregular mass arising from the upper and middle parts of the right kidney and that none of the margins of this mass were well defined. The scan stated that the appearances were suggestive of early retroperitoneal invasion. A 1.7 centimetre lymph node was seen very close to the main mass.

11. The Adviser continued that Consultant 4 reported the case and showed the x-rays at the multi-disciplinary team meeting on 6 February 2007 and although minutes were not recorded, there is an email from Consultant 4 to Consultant 1 on 7 February 2007, in which he stated that surgery was advisable and that he would refer Mr C to Consultant 2. Mr C was due to see Consultant 1 at the renal clinic on 28 February 2007 but did not attend. Consultant 1 then wrote to Mr C and told him that arrangements had been made for him to see Consultant 2 on the renal ward on 6 March 2007. In a letter to Mr C's GP, Consultant 1 stated '… The risks and benefits (of surgery) were gone over with [Mr C]. [Mr C] has opted for surgery and is aware that he will almost certainly be rendered dialysis dependent by the procedure … [Mr C] has an appointment to see [Consultant 2] next week … with some family members'. An email from Consultant 2 to Consultant 1 dated 14 March 2007 confirmed that Consultant 2 met Mr C and his family and that, in his opinion, the

nephrectomy was necessary. It was also explained that Consultant 2 had explained the risks and limitations of surgery, which was scheduled for 12 April 2007.

12. The Adviser noted that Mr C had signed the consent form for right nephrectomy but did not date it. The form also contained an unreadable signature, dated 12 April 2007. The consent form is not accompanied by any other details and there is no evidence that the medical signatory dealt with the details of the operation, possible complications, etc. The Adviser said that post-operatively Mr C's kidney function was further reduced. This was not unexpected, since an earlier test on 8 March 2007 had shown that the right kidney at that time was contributing 57 percent of the total renal function. Mr C's kidney function continued to deteriorate and he started on regular haemodialysis at the end of May 2007. On 15 May 2007, Consultant 2 wrote to Mr C and stated that the histological examination of the removed kidney had shown no signs of cancer. Consultant 2 also commented that, despite this, surgical removal had been the correct decision.

13. The Adviser continued that, as Mr C had started long term dialysis (six weeks following the nephrectomy), the nephrology team later considered Mr C for the possibility of renal transplantation. This was during the time that Mr C was pursuing his complaint through the NHS complaints procedure. A consultant asked the pathology department to review the kidney histology. The reasoning behind this was, correctly, that transplantation in a situation where there was a possibility of recent or existing malignancy would be unwise. The pathologist then requested a second opinion from outwith the Board area and it was concluded, in a report dated 14 November 2007 (after Mr C had submitted his complaint to the Ombudsman), that the clusters of cells in the kidney material represented a small amount of viable tumour and that the mass (the original kidney lesion) had originally been clear cell carcinoma (cancer) of the kidney. The Board have informed me that Consultant 1 met with Mr C while he was an in-patient to explain the results of the additional pathology which had been obtained. The Adviser said it was clear from the further opinion on the tissue that the amount of tumour in the sample was small and it was probable that a biopsy would have given false negative results.

14. The Adviser felt that the radiological investigations in December 2006 and January 2007 were very suggestive of a malignant growth in Mr C's kidney. He thought the views expressed by Consultant 2 concerning the reasons for not

performing a biopsy of the mass were correct. He added that a biopsy obtains only a small sample of tissue and a negative finding, ie, no cancer, cannot be taken as proof of absence of a tumour because of the possibility of sampling error. The Adviser also agreed that the biopsy of a tissue which is potentially malignant risks the dissemination of cancer cells into the bloodstream. In addition, as renal tumours may be quite vascular, there is also a risk of post-biopsy haemorrhage.

15. The Adviser considered whether the clinicians could have carried out further investigations prior to the removal of the kidney. He mentioned that a renal arteriogram could have been considered as this would outline the arteries of the kidney and should a tumour be present it may show abnormal blood vessels going to and within the tumour. However, this procedure may also not detect tumours with little vascularity and not all vascular tumours are malignant. The Adviser thought that even if a renal arteriogram had been performed, it would have been unlikely to lead to different advice from Consultant 1 and Consultant 2. The Adviser also questioned whether the clinicians had considered whether to examine Mr C's urine for the presence of cancer cells (urine cytology). However, the Adviser commented that this type of investigation can also be negative despite the presence of cancer. The Adviser believed that the nephrectomy would have been advised irrespective of whether urine cytology had been requested. The Adviser told me there was no doubt that dialysis was inevitable for Mr C even if the nephrectomy had not been performed. He felt that, as Mr C's kidney function was operating at 13 percent of normal, some renal units would already have started dialysis. In the Adviser's opinion, the loss of Mr C's right kidney reduced the overall function to about 6 percent and brought forward the need for dialysis by only a few months. He continued that the decision to proceed to nephrectomy without further investigations, including biopsy, was justified and in Mr C's best interests.

16. In response to an enquiry the Board told me that, prior to the nephrectomy, no consideration was made as to whether further investigations were necessary. They explained that renal angiogram is an invasive investigation and the sensitivity of modern CT scan for vascularity is such that they are unhelpful and in Mr C's case the results would likely have produced a false negative. Urine cytology is not usually positive in the sort of tumour which Mr C had and it is not quoted in any of the lists of diagnostic aids for renal carcinoma. The Adviser fully accepted the Board's explanations in this regard

and he remained of the opinion that the decision to proceed to nephrectomy without further investigations was reasonable.

(a) Conclusion

17. Mr C felt that when he received the letter from Consultant 2, which told him that the pathology on the removed kidney showed no trace of cancer, further investigations should have been carried out on the suspected cancerous lump before a decision was taken to remove his right kidney. He believed this led to him having to undergo dialysis far in advance of what was required. The advice which I have received, and accept, is that the decision to proceed to nephrectomy without further investigations was correct, in view of the possibility that the results would likely produce false negatives about the presence of cancer. Therefore, in the circumstances, I have decided not to uphold this aspect of the complaint. I am also conscious that the final pathology report, obtained before a decision could be made on whether Mr C was a suitable candidate for kidney transplant, established that there were in fact small traces of cancer present which was an indication that further tests undertaken prior to the nephrectomy would likely have proved inconclusive. While I can understand the view that Mr C has taken, I can find no grounds to question the clinical treatment which he received. The Adviser has also commented on the way in which the consent form is documented. While I am not upholding the complaint, the Ombudsman has the following recommendation to make.

(a) Recommendation

18. The Ombudsman recommends that the Board reflect on the Adviser's comments in relation to the way in which the consent was documented and consider whether they need to make any changes to procedure.

(b) Conclusion

19. Mr C said he was astounded to be told in a letter from Consultant 2 which stated that the tests which were carried out on his removed kidney proved it to be non-cancerous and that it was hoped that he was doing well. His life had changed dramatically and he felt he should have been told of the result at an appointment rather than in an offhand letter. The Board have explained that, as Mr C was then attending the Hospital for further treatment several times a week, it was felt that the quickest and least inconvenient way of contacting him with the results was by letter and that as it was good news and the letter was very positive. I appreciate that it would be difficult to judge the correct way in which to impart the news to Mr C. While it was good news, based on the result

available at that time, that it was non-cancerous was always likely to distress Mr C, who then believed that the nephrectomy had not actually been required and therefore had hastened his requirement for dialysis. Mr C was at that time attending the Hospital for treatment and I believe that the opportunity should have been taken to arrange an appointment around the times he was on the premises. This would have allowed the medical staff to provide further information and be available to answer any questions which he may have had. Accordingly, I have decided to uphold this complaint. While the Board have apologised to Mr C if he found the manner in which he was told distressing, nevertheless, it is clear that Mr C did find this situation distressing.

(b) Recommendation

20. The Ombudsman recommends that the Board make Mr C a further full and meaningful apology.

21. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Lanarkshire NHS Board
The Hospital	Monklands Hospital
The Adviser	Ombudsman's professional medical adviser
The Manager	The Board's Interim General Manager for the Surgical & Critical Care Clinical Division
Consultant 1	Consultant nephrologist
Consultant 2	Consultant urologist
Consultant 3	Consultant radiologist who reported the scan results
Consultant 4	Consultant urologist who took the results to the multi-disciplinary team meeting
CT scan	Computed Tomography Scan

Annex 2

Glossary of terms

Benign	Non-cancerous
Computed Tomography Scan (CT scan)	Scan of internal organs using a computer which takes data from multiple x-ray images and converts them into pictures
Haemodialysis	Cleaning of the blood by a machine outwith the body
Lymph nodes	Small glands within the lymphatic (body drainage) system
Malignant	Cancerous
Nephrectomy	Removal of one kidney
Nephropathy	Kidney disease
Retroperitoneal	At the back of the abdominal cavity, behind the peritoneal membrane
Ultrasound scan	View of internal body organs using soundwaves
Vena cava	The main vein draining the lower part of the body