Scottish Parliament Region: North East Scotland

Case 200801545: Grampian NHS Board

Summary of Investigation

Category
Health: Hospital; clinical treatment; diagnosis

Overview
The complainant (Miss C) raised a number of concerns about the care and treatment that her late father (Mr A) had received before his death.

Specific complaint and conclusion
The complaint which has been investigated is that Grampian NHS Board (the Board) did not provide reasonable care and treatment to Mr A in relation to a referral from his GP for hoarseness (*upheld*).

Redress and recommendations
The Ombudsman recommends that the Board:

(i) ensure that all clinical staff are aware that persistent hoarseness should be taken to be a symptom of cancer of the larynx unless proved otherwise;
(ii) ensure that such cases are dealt with urgently;
(iii) ensure that endoscopies undertaken to exclude cancer have the direct involvement of a senior trained practitioner;
(iv) ensure that any junior staff involved in such procedures are adequately trained and supervised and that this is recorded;
(v) review the way in which the laryngoscopy performed on Mr A in 2005 was carried out to establish if there are any lessons that can be learned and whether further guidelines in relation to such procedures are required;
(vi) consider further investigation where a laryngoscopy shows no evidence of malignancy, but the patient continues to display laryngeal symptoms; and
(vii) apologise to Miss C for the failings identified in this report.

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

Main Investigation Report

Introduction

1. The complainant (Miss C) complained to the Ombudsman about the treatment that her late father (Mr A) had received from his GP Practice (the Practice) before his death on 6 March 2007. The Ombudsman's medical adviser (Adviser 1) was asked to comment on the complaint. In his response, Adviser 1 said that the Practice had acted reasonably, but that he was concerned that there may have been errors in the tests completed at Aberdeen Royal Infirmary (the Hospital). On 28 August 2008, Miss C confirmed that she wished to pursue a complaint about the care and treatment that Mr A received from Grampian NHS Board (the Board).

2. The complaint from Miss C which I have investigated is that the Board did not provide reasonable care and treatment to Mr A in relation to a referral from his GP for hoarseness.

Investigation

3. Investigation of the complaint involved reviewing Mr A's medical records relating to the events and the Board's complaints file. I also sought the views of specialist medical advisers to the Ombudsman.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

5. On 14 July 2004, the Practice made a referral to the Hospital for a chest x-ray. They also made a referral to the Hospital's ENT clinic for a laryngoscopy, as Mr A had complained that he had been suffering from hoarseness for four to five months. The chest x-ray was completed on 5 August 2004. This showed normal appearances.

6. On 10 March 2005, the Hospital advised the Practice that Mr A's hoarseness was getting worse and was now permanent. They said that his larynx looked abnormal, but they were not quite sure what was going on or whether it was the result of the stroke he previously had. They said that he would be referred for a laryngoscopy. A microlaryngoscopy and biopsies from the right and left vocal cords were carried out on 26 April 2005. The Hospital wrote to the Practice on 28 April 2005 to advise that the microlaryngoscopy had

revealed thickened, polypoidal vocal cords. They said that Mr A would be reviewed in one month, with the result of the biopsies. The Hospital wrote to the Practice again on 10 June 2005 and said that the vocal cord biopsies simply showed mild oedema and no evidence of malignancy. They said that they had discharged him to the Practice's care.

7. The Practice referred Mr A for a further chest x-ray on 10 February 2006. They said that he had an ongoing problem with a cough, wheezing and hoarseness. They asked for the x-ray because Mr A was a long-term smoker and they wanted to ensure that there was nothing else that was causing the symptoms.

8. On 13 February 2006, the Practice recorded that Mr A had stridor and that his condition was worsening. It was also recorded that he was confused and agitated at times and that he required urgent hospital admission and assessment. Mr A was admitted to the Hospital on 15 February 2006. The Practice asked that someone look at Mr A urgently because of his worsening hoarseness. They said that stridor was now obvious at rest and that Mr A showed evidence of breathlessness. They also said that he had visual hallucinations and agitation.

9. The Hospital recorded that on initial examination, it was readily apparent that Mr A had an advanced supraglottic laryngeal tumour. Mr A's condition deteriorated and a surgeon attempted to remove as much of the tumour as possible. The procedure was initially successful in maintaining his airway, but Mr A's condition deteriorated again and an emergency tracheostomy was carried out on 18 February 2006. Following this, the Hospital were able to optimise Mr A's lung function and a total laryngectomy was carried out on 24 February 2006. Mr A was discharged on 15 March 2006 with a plan to commence radiotherapy.

10. Mr A was readmitted to the Hospital on 22 June 2006 and a voice prosthesis was fitted on 26 June 2006. On 25 October 2006, a consultant from the Hospital advised Mr A's GP that he was doing extremely well following total laryngectomy and prosthetic voice restoration. He also said that there was no evidence of any disease in the relevant region and that Mr A would be seen again in four months' time.

11. However, on 26 January 2007, a GP visited Mr A at home and recorded that he was suffering from lower back pain. The GP subsequently recorded that he was concerned that Mr A may have secondary cancer in his liver from his laryngeal cancer and that he would discuss the matter with an ENT consultant. Mr A's condition deteriorated rapidly and he was admitted to the Hospital for further investigation on 29 January 2007. Mr A died in the Hospital on 6 March 2007, as a result of secondary disease from his original laryngeal cancer.

Complaint: The Board did not provide reasonable care and treatment to Mr A in relation to a referral from his GP for hoarseness

12. In response to the concerns raised by Adviser 1 I requested comments on the matter from the Board. They said that they had spoken to two consultants, one of whom had been involved in Mr A's treatment. They said that both agreed that there was no error in the pathology. They said that Mr A had been a heavy smoker and this was a known cause of head and neck cancer. They said that there was no tumour present at the time of the original biopsy and it was logical to conclude that a malignant transformation occurred at a later stage. They said that the consultant involved in Mr A's treatment did not believe that there had been any substandard treatment or errors and that the care and treatment seemed to have been undertaken appropriately.

13. After I had considered the Board's response, I requested comments from a specialist ENT adviser (Adviser 2). In his response, he said that persistent hoarseness of voice is taken by all doctors in the UK as a symptom of cancer of the larynx unless proved otherwise. He said that Mr A's persistent unabating hoarseness of voice should have been treated with a great deal of clinical suspicion and concern. Adviser 2 said that endoscopies undertaken to prove or exclude cancer have to have the direct involvement of a senior trained practitioner. In Mr A's case, although the consultant was in the theatre, the operation was performed by a junior doctor. I asked the Board for further information in relation to the involvement of the consultant. In their response, they said that the consultant had now retired, but that the junior doctor had stated that the presence of the consultant in the theatre was proof that the procedure was supervised.

14. Adviser 2 referred the slides from the biopsies completed in 2005 and 2006 to a specialist pathology adviser (Adviser 3) for review. In his response, Adviser 3 commented that one of the biopsies taken in 2006 showed evidence of malignancy, but there was no evidence of this in the biopsies taken in 2005.

His conclusion was that either the tumour had arisen in the interval between the two biopsies or, what seemed more likely, the biopsies were not taken from the same place within the larynx. He stated that either way, there did not seem to be any evidence of misdiagnosis by the pathologist who was asked to report on the sample taken in 2005. Adviser 2 stated that he suspected that the biopsy taken at that time was unrepresentative of what was described as asymmetrical larynx.

15. The consultant at the Hospital saw Mr A on 10 June 2005 and discharged him from his care, despite the persistent hoarseness in an asymmetric larynx. Adviser 2 said that a CT scan at that time would have helped provide the reason for persistent laryngeal symptoms. The Board have advised us that CT scan is often not utilised, as they do not consider that it is as good an investigation as an MRI scan.

16. Adviser 2 also commented that Mr A was found to have an extensive supraglottic tumour in February 2006, which extended down to the surface of the glottis and distorted the larynx. He stated that a tumour of this size takes a long time to develop. He concluded that Mr A's symptoms and signs were not taken with adequate concern and the biopsies completed in 2005 made people dismiss him rather prematurely.

17. Adviser 2 stated that the fact that the hoarseness was progressive and that Mr A died from secondary cancer indicates that the disease was probably there from 2004. He said that it was unlikely that such advanced disease that distorted the larynx developed in the intervening period. Adviser 2 expressed concern about the lack of awareness of how serious hoarseness of voice can be.

18. I sent a copy of a draft version of this report to the complainant and to the Board for comment in line with our normal procedure. In their response, the Board said that the junior doctor who carried out the operation was now a consultant. He had read the draft report and considered that the comments made about the tumour by Adviser 2 and Adviser 3 were speculative and lacked definitive evidence. He stated that it was not uncommon for biopsies to be negative at initial presentation, but for definitive malignancy to be identified later. He said that there was not a temporal growth of tumour in every single case. He said that some tumours are far more aggressive and can grow over a short period of time, as opposed to others that take a long time to develop. He

also said that there was no evidence that the tumour was present from 2004. The consultant stated that he had seen patients in his own practice who, soon after diagnosis, had presented with metastases.

Conclusion

19. I have carefully considered the evidence, the advice I have obtained and the comments I have received from Miss C and the Board. I accept Adviser 2's comments that Mr A was dismissed prematurely in response to persistent hoarseness in an asymmetrical larynx. Further investigation would have provided diagnostic information and this would have been preferable to discharging him with continuing laryngeal symptoms. This would be true regardless of whether or not cancer was present in 2005. The Board have stated that it is not uncommon for biopsies to be negative at initial presentation, but for definitive malignancy to be identified later. This is additional evidence that further investigation should have been carried out. There was also a delay in carrying out the laryngoscopy in 2005. Although the operation notes show that the consultant was in the theatre during this procedure, they do not confirm that he was directly involved.

20. In view of all of the above, I uphold the complaint.

Recommendations

21. The Ombudsman recommends that the Board:

(i) ensure that all clinical staff are aware that persistent hoarseness should be taken to be a symptom of cancer of the larynx unless proved otherwise;

(ii) ensure that such cases are dealt with urgently;

(iii) ensure that endoscopies undertaken to exclude cancer have the direct involvement of a senior trained practitioner;

(iv) ensure that any junior staff involved in such procedures are adequately trained and supervised and that this is recorded;

(v) review the way in which the laryngoscopy performed on Mr A in 2005 was carried out to establish if there are any lessons that can be learned and whether further guidelines in relation to such procedures are required;

(vi) consider further investigation where a laryngoscopy shows no evidence of malignancy, but the patient continues to display laryngeal symptoms; and

(vii) apologise to Miss C for the failings identified in this report.

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

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mr A	The aggrieved – Miss C's father
The Practice	Mr A's GP Practice
Adviser 1	Medical adviser to the Ombudsman
The Hospital	Aberdeen Royal Infirmary
The Board	Grampian NHS Board
ENT	Ear, Nose and Throat
Adviser 2	Specialist ENT adviser to the Ombudsman
Adviser 3	External specialist pathology adviser

Annex 2

Glossary of terms

CT scan	A special radiographic technique that uses a computer to assimilate multiple x-ray images into a two dimensional cross-sectional image
Endoscopy	An examination of the interior of a bodily canal or a hollow organ by use of an instrument called an endoscope
Glottis	The vocal apparatus of the voice box
Laryngeal	Having to do with the voice box
Laryngectomy	The surgical removal of the voice box
Laryngoscopy	The visualisation of the voice box and vocal cords using a fibre optic scope or mirrors
Larynx	The voice box
Metastases	Cancer that started from cancer cells from another part of the body
Oedema	Swelling from accumulation of fluid
Polypoidal	A usually non-malignant growth or tumour
Stridor	The harsh sound heard on inhalation caused by air passing through a constricted passage
Supraglottic laryngeal tumour	A tumour above the glottis
Tracheostomy	A surgical procedure to create an opening in the front of the windpipe