Scottish Parliament Region: South of Scotland

Case 201104810: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns against Ayrshire and Arran NHS Board (the Board) about delays in diagnosing and treating her thyroid cancer at Crosshouse Hospital, Kilmarnock. Mrs C believed this was due to mistakes, confusion and poor communication and support by hospital staff and had felt 'massively let down' by what had happened to her.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C was not given reasonable information, advice or support about the lump on her neck, and the possible risk of cancer, to allow her to make informed decisions about her treatment (*upheld*);

(b) nobody took reasonable steps to follow up, after the time Mrs C was timetabled for the operation, to ensure that the lump had not changed or to arrange a further operation date (*upheld)*;

(c) staff unreasonably failed to carry out further tests when the lump was first discovered (*not upheld*); and

(d) the Board failed to provide a reasonable explanation of both the process which would be followed in relation to the scan offered in March/April 2011 and also the scan results themselves *(not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) share the comments of the Adviser, in relation to complaint (a), with the relevant hospital staff to ensure that full information is given to a patient on the need for surgery and that this is documented in the patient's medical records;	21 August 2013
(ii) issue Mrs C with a full and sincere apology for the	19 June 2013

failings identified in complaint (a);

(iii)	consider changing their current practice so that where a patient cancels their surgery for a putative benign lesion, the hospital department concerned contacts the patient again, in a form that is documented, and records either the need for surgery or a follow-up appointment; and	21 August 2013
(iv)	issue Mrs C with a full and sincere apology for the failings identified in complaint (b).	19 June 2013

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

Main Investigation Report

Introduction

1. Mrs C initially visited her General Practitioner (the GP) after finding a large lump at the side of her neck in or about October/November 2009. At that time Mrs C had been under the care of a consultant endocrinologist (Consultant 1), at Crosshouse Hospital, Kilmarnock (the Hospital) for a number of years as she had an overactive thyroid and Graves Disease. As the GP thought the lump may have been connected to her thyroid condition she, therefore, saw Consultant 1 at the Hospital. Test results suggested she had a branchial cyst (the cyst).

2. Mrs C was advised in January 2010 that she should have the cyst surgically removed under general anaesthetic. The surgery was to be performed by an ear, nose and throat (ENT) surgeon (Consultant 2) at the Hospital. At the time, Mrs C had a son who was a few months old whom she was breastfeeding. Therefore, Mrs C said that she contacted Consultant 2's office and asked if the surgery was essential. Mrs C said that she was told the cyst was 'nothing sinister' and that surgery to remove the cyst was not urgent. In view of what she was told, Mrs C decided to delay the surgery.

3. A year later, having had no further contact from the Hospital, Mrs C requested that the GP refer her back to the Hospital to discuss having the cyst removed. She was given an appointment with Consultant 2 for March 2011. However, prior to seeing Consultant 2, she had a routine appointment with Consultant 1, also in March 2011, when a nodule on her thyroid was discovered. Consultant 1 arranged for biopsies to be taken of the nodule and the cyst. Shortly thereafter, Mrs C was told that papillary carcinoma cells had been found within the thyroid nodule and the cyst. Mrs C subsequently had surgery (a thyroidectomy and right neck dissection) in May 2011.

4. Mrs C considered that the Hospital's failure to inform her that the cyst could be cancerous and the delay in diagnosing her cancer had affected her chance of recovery. Mrs C also believed she was poorly supported by hospital staff.

5. The complaints from Mrs C which I have investigated are that:

(a) Mrs C was not given reasonable information, advice or support about the lump on her neck, and the possible risk of cancer, to allow her to make informed decisions about her treatment;
(b) nobody took reasonable steps to follow up, after the time Mrs C was timetabled for the operation, to ensure that the lump had not changed or to arrange a further operation date;
(c) staff unreasonably failed to carry out further tests when the lump was first discovered; and
(d) the Board failed to provide a reasonable explanation of both the process which would be followed in relation to the scan offered in March/April 2011 and also the scan results themselves.

Investigation

6. Investigation of the complaint involved reviewing copies of Mrs C's medical records, the complaints correspondence received from Ayrshire and Arran NHS Board (the Board), the response from the Board to written enquiries made by this office and also the information supplied by Mrs C. As the complaint included clinical issues, my complaints reviewer obtained clinical advice from one of the Ombudsman's medical advisers who has a background in Endocrinology and experience in investigating and managing patients with thyroid cancer (the Adviser).

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

(a) Mrs C was not given reasonable information, advice or support about the lump on her neck, and the possible risk of cancer, to allow her to make informed decisions about her treatment

8. Mrs C said that when she initially saw Consultant 1 about the lump in her neck on 14 October 2009, he told her that he did not think the neck lump was attached to her thyroid. Consultant 1, therefore, referred her for an ultrasound scan. As the scan was unable to determine what the neck lump was, Consultant 1 referred her to the Hospital's Neck Lump Clinic. Mrs C attended the clinic on 28 October 2009 where she was seen by a speciality doctor in the ENT Department (Doctor 1), and a fine needle aspiration (FNA) biopsy of the neck lump was performed. On 6 November 2009 Doctor 1 sent a letter to Mrs C about the results of the FNA. It stated that he was:

'pleased to say that [the results of the FNA performed on the neck lump] showed no worrying features and suggested that the lump is inflammatory and cystic.'

9. Mrs C then saw Consultant 2 at the Neck Lump Clinic on 9 December 2009. Following this she received a letter from the Hospital giving her an appointment to have the cyst surgically removed in January 2010. This was to be performed by Consultant 2. Mrs C said that as her son was only a few months old and she was still breast feeding she, therefore, contacted Consultant 2's office and spoke to his secretary. She asked if the surgery was essential or if could be carried out at a later date. Mrs C said that she was assured by Consultant 2's secretary that the surgery was not urgent as it was only a cyst. She was told to contact the Hospital at a later date if she wanted to go ahead with the surgery.

10. However, nobody suggested to Mrs C that she should have the surgery in January 2010 in case the cyst turned out to be cancerous. It was also not made clear to her that FNAs were not 100 percent accurate. Mrs C said she only learned of this approximately sixteen months later when her cancer diagnosis was made. No-one had ever cautioned her against not proceeding with the operation or had seemed concerned that she did not go ahead with it. Mrs C considered she had been made to feel guilty when she had telephoned to ask if the operation was necessary and if it could be delayed, even though she had been told that this was not a problem. Mrs C also believed that the support offered was not good enough.

11. The Board, in response to the complaint, stated that Mrs C had been diagnosed with hyperthyroidism secondary to Graves Disease by Consultant 1 in July 2007, having been referred to the Hospital's Endocrine Clinic that year. Following discussion of the potential treatment options, Mrs C had elected to start treatment with anti-thyroid drugs and had been made aware of their side effects. Due to a lack of effectiveness the drug was discontinued and Mrs C was placed on alternative medication, which achieved good control of her condition.

12. In 2008 Mrs C became pregnant and was reviewed at the Endocrine Clinic in January 2009, when she was 11 weeks pregnant. Endocrine review was scheduled at regular intervals across her pregnancy and her anti-thyroid

medication was progressively down-titrated (adjusting the dosage of Mrs C's medication downwards) during her pregnancy.

13. Mrs C attended the Endocrine Clinic for review in October 2009, which was approximately six weeks after she had given birth to her son. She described a recent upper respiratory tract infection and the emergence of a small right sided neck lump two weeks predating the clinic appointment. Clinical examination revealed the presence of a moderate size goitre, similar in size and character to that noted by Consultant 1 on previous clinical assessments. However, there was also the presence of a new right sided neck lump in the lateral aspect of the anterior triangle of her neck. The nature of the lump was uncertain so Consultant 1 arranged for Mrs C to undergo an ultrasound scan of her neck which was carried out one week later.

14. The ultrasound scan confirmed the presence of the cyst, which was located lateral to the right lobe of the thyroid. As the lump did not appear to be anatomically related to the thyroid, a referral was made to the ENT Neck Lump Clinic. Mrs C was informed by Consultant 1 of the ultrasound scan results at the same as the scan was carried out. Consultant 1 then promptly referred Mrs C for further investigation to the ENT Neck Lump Clinic six days after the scan was performed, at which an FNA of the lump was taken with arrangements to review Mrs C when the results were available. Mrs C was written to on 6 November 2009, nine days after the FNA, informing her that the FNA had shown no worrying features and suggested the lump perhaps was inflammatory or cystic (see paragraph 8).

15. A review appointment was arranged for Mrs C to attend the Neck Lump Clinic to discuss the results further with Consultant 2 on 9 December 2009. At this consultation, Consultant 2 clearly advised Mrs C to have the lump removed because FNAs are not one hundred per cent accurate. Mrs C was subsequently offered a date for surgery. This was documented clearly in Mrs C's case notes. Mrs C declined the offer, as she was breastfeeding, and stated that she would contact the Hospital when it was more convenient for her.

16. The Board explained that patients would not be added to a waiting list unless surgery was deemed necessary. It was not normal practice for the Hospital to contact patients after the patient had cancelled an appointment for their procedure. The Hospital would always ask the patient to contact them when they wished to be given a further date for surgery. Consultant 2's

secretary would have confirmed that Mrs C was placed on the waiting list as a routine case as, at that point, there was no evidence that the neck lump was serious. However, the clear recommendation from Consultant 2 at that time, as recorded in Mrs C's medical records, was that the lump should be removed.

17. The Board also stated that during this period they believed that Mrs C had been provided with the appropriate support by all those involved in her care. Mrs C was offered referral to both Social Work for benefits and childcare advice but Mrs C declined this, as she said she had good family support. An initial referral of support from Ayrshire Cancer Support was declined by Mrs C in May 2011, although she later agreed to this and, therefore, the Cancer Nurse Specialist contacted them asking that they assess Mrs C for some counselling and complementary therapies. The Board believed, therefore, that Mrs C was provided with the appropriate support and advice during this period.

Clinical Advice

18. The Adviser said that he considered the investigations carried out on Mrs C's neck lump were appropriate and performed with the necessary speed. The Adviser was of the view that the flow of Mrs C through the Hospital's medical system from the Endocrine clinic through radiology to the ENT surgical department and the offer of surgery was timely.

19. However, the Adviser also considered that from his review of Mrs C's medical records, it was extremely difficult to be certain how much information was communicated to her about the nature of the neck lump. Mrs C was told that clinicians considered the lump to be benign in nature and it was probably a branchial cyst. Mrs C was also told that she needed an operation and surgical removal of the lump. However, it was not stated anywhere in Mrs C records that she was told that the diagnosis of the cyst was preliminary and that only pathological examination of the lump could identify its nature; also, that there was a possibility that the lump might prove to be malignant in nature.[1] The Adviser also told my complaints reviewer there was no evidence that Mrs C was told that without a pathological diagnosis the possibility that she had some form

[1] The entry in the notes for 9 December 2009 reads '- surgery? Branchial cyst R side' underneath this it appears to read 'Non-smoker'. In a follow-up letter to Mrs C's GP practice Consultant 2 confirms he considers this was probably a branchial cyst. He states he explained the options to Mrs C and that he would recommend surgery. He confirms that he would be in contact with Mrs C's admission date in due course.

of cancer could not be excluded, which was the primary reason that surgery had to be performed.

20. The Adviser further told my complaints reviewer that, clearly, Mrs C did not understand that the lump might be malignant, albeit that it was not the most likely diagnosis. The Adviser was of the view that if Mrs C had understood the risk, it was extremely improbable that she would have cancelled the surgery or, if she had, she would have rearranged the surgery very soon thereafter. Therefore, he believed that Mrs C was not in a position to make an informed decision about her treatment.

(a) Conclusion

21. The advice I have received from the Adviser is that Mrs C was told that her neck lump was probably a benign cyst and that the lump should be surgically removed, as is confirmed in Mrs C's medical records. While Consultant 2 confirmed in a letter to Mrs C's GP practice that he had explained the options to her, there was no evidence in Mrs C's medical records that she was made aware that this diagnosis was only preliminary and the neck lump might be cancerous; and that only pathological examination of the lump following surgery could identify its nature and until then, the possibility that she had some form of cancer could not be excluded. I accept that advice.

22. Furthermore, as the Adviser has stated in his advice to my office and with which I agree, had Mrs C been in possession of these facts and understood the risk, it was highly unlikely that she would have cancelled her surgery or, if she had, it was likely she would have rescheduled it for very soon thereafter.

23. Therefore, I accept the advice of the Adviser that Mrs C was not in a position to make an informed decision about her treatment.

24. Having carefully considered the evidence, I am not persuaded there was a failure by the hospital staff involved in Mrs C's care to offer her reasonable support.

25. However, given that I have concluded that Mrs C was not provided with the relevant information and advice about the lump on her neck so as to allow her to make an informed decision about her treatment, I uphold the complaint.

(a) Recommendations

26. I recommend that the Board:	*Completion date*
(i) share the comments of the Adviser, in relation to this complaint with the relevant hospital staff to ensure that full information is given to a patient on the need for surgery and that this is documented in the patient's medical records; and	21 August 2013
(ii) issue Mrs C with a full and sincere apology for the failings identified in this complaint.	19 June 2013

(b) Nobody took reasonable steps to follow up, after the time Mrs C was timetabled for the operation, to ensure that the lump had not changed or to arrange a further operation date

27. Mrs C said that, as she had not heard from the Hospital for more than a year after cancelling surgery in January 2010, she contacted the GP and asked to be referred back to the Hospital to discuss having the cyst removed. She was given an appointment with Consultant 2 for 23 March 2011. However, prior to this, she had a routine appointment with Consultant 1 on 10 March 2011. At this appointment a nodule on her thyroid was discovered. Consultant 1 arranged for biopsies of the nodule and the cyst. Shortly thereafter, Mrs C was told by Consultant 1 that papillary carcinoma cells had been found within the thyroid nodule and the cyst. Consultant 1 explained to her that she would have to have her thyroid removed and that she would have the surgery within the next few weeks.

28. In their response to the complaint, the Board restated that it was not normal practice for the Hospital to contact patients after the patient has cancelled their appointment. In such circumstances, the responsibility was put back onto the patient to contact the Hospital when they were available to come in for surgery. In Mrs C's case she had intimated that she would contact the Hospital direct when it was more convenient for her to have surgery, as she was still breastfeeding her son.

29. Mrs C thereafter continued to attend the Endocrine clinic at regular intervals for the management of her hyperthyroidism. At a routine review appointment on 10 March 2011 the presence of a visible nodule in the region of the right lobe of her thyroid was noted. Clinical examination revealed the presence of a firm nodule in the right lobe of the thyroid but also that the right sided neck lump had increased in size. FNA biopsies of the thyroid nodule and

the neck lump were performed at the time of the clinic appointment on 10 March 2011 and the results were reported on 15 March 2011. These were suggestive of a metastatic papillary carcinoma of the thyroid.

Clinical Advice

30. The Adviser told my complaints reviewer that, from his review of the medical records and witness statements, there was no evidence that any member of the medical staff had discussed or considered the possible health implications of a delay to Mrs C's planned operation in January 2010. Clinical staff took no steps to follow up Mrs C after the initial operation was cancelled.

31. As far as Mrs C was concerned, her reasons for cancelling the initial operation were perfectly valid. However, Mrs C was clearly unaware that a malignant pathology had not been 100 percent excluded from her clinical assessment and investigations. Therefore, in view of this, the Adviser has told my complaints reviewer that some form of contact with Mrs C was essential. In the Adviser's view, the Hospital could and should have contacted Mrs C in a variety of ways, either by telephone so as to emphasise with her the need for surgery with a transparent explanation as to why it was necessary, by fixing a new date for surgery or by a clinical follow-up appointment at the Hospital, so as to determine if the neck lump had changed.

32. In the Adviser's opinion, where a patient cancels their surgery for a putative benign lesion, the Board should change their usual practice of leaving future contact entirely in the patient's hands. According to the Adviser, it is crucial that the Board appreciate that the diagnosis/labelling of a lesion as benign is a preliminary process and a major reason why such a lesion is surgically removed is to exclude all possibility that it might be due to a malignant process. Under these circumstances it was the Adviser’s view that the hospital department concerned should always contact the patient again, preferably in a form that is documented, such as an explanatory letter, as to the need for surgery or a follow-up appointment to determine if the lesion has changed or a letter offering a rearranged operation date. The Adviser stated that in these circumstances, leaving it entirely in the hands of a patient to follow up (who may be unaware that a malignant process has not been formally excluded), is unacceptable.

(b) Conclusion

33. As I have concluded in complaint (a) above, there is no evidence that Mrs C had been made aware that the diagnosis of her neck lump as a benign cyst was only preliminary and that only pathological examination of the lump following surgery could identify its nature and until then the possibility of cancer could not be excluded. For this reason, I accept the advice of the Adviser that the Hospital should not have left it entirely up to Mrs C to contact the Hospital to rearrange surgery following her cancellation of the initial operation in January 2010. Furthermore, I also accept his advice that, for the reasons set out in paragraph 32 of this report, where a patient cancels their surgery for a putative benign lesion the Board should change their normal practice of leaving future contact with the Hospital entirely in the patient's hands.

34. Therefore, I consider there was a failure by the Hospital to follow up Mrs C, after she had cancelled surgery in January 2010, to ensure that the lump on her neck had not changed or to arrange a further date for surgery.

35. Accordingly, I uphold the complaint.

(b) Recommendations

36. I recommend that the Board:	*Completion date*
(i) consider changing their current practice so that, where a patient cancels their surgery for a putative benign lesion, the hospital department concerned contacts the patient again, in a form that is documented, and records either the need for surgery or a follow-up appointment; and	21 August 2013
(ii) issue Mrs C with a full and sincere apology for the failings identified in this complaint.	19 June 2013

(c) Staff unreasonably failed to carry out further tests when the lump was first discovered

37. Mrs C complained that she felt the initial failure to follow up and carry out further tests when the lump was first discovered, delayed her diagnosis and possibly reduced her chances of recovery.

38. The Board stated that, as set out in detail in their response to complaint (a), Consultant 1 had arranged for Mrs C to have an ultrasound scan after the emergence of the lump on her neck. Following the outcome of this,

Consultant 1 had then made arrangements for Mrs C's case to be transferred to the Hospital's ENT Department, who arranged for her to have a FNA biopsy of the lump and thereafter surgery was recommended. The scan and recommendation for treatment was carried out when the lump was first discovered.

Clinical Advice

39. The Adviser has told my complaints reviewer that he considered the investigations which were carried out by the Hospital were, in his clinical opinion, the right tests and were reasonable and appropriate. They were performed with the necessary speed and the flow of Mrs C through the medical system from the Endocrine clinic, to radiology, to seeing an ENT surgeon and a date for the surgical removal of the lump was timely.

40. Furthermore, the Adviser did not believe that it had been necessary to have performed a computed tomograph (CT) scan when the lump was first discovered. If, however, the first FNA biopsy had revealed papillary thyroid cancer cells then a CT scan should have followed swiftly. However, given that the FNA findings were benign, the Adviser considered that planned surgical removal of the lump was appropriate without a CT scan.

(c) Conclusion

41. The clinical advice I have received is that the investigations of Mrs C's neck lump were correct and appropriate and carried out without delay. Furthermore, given that the lump was considered to be benign, the planned surgical removal of the lump without a CT scan was also appropriate. I accept that advice.

42. Therefore, I do not uphold the complaint.

(d) The Board failed to provide a reasonable explanation of both the process which would be followed in relation to the scan offered in March/April 2011 and also the scan results themselves

43. Mrs C said that, following her cancer diagnosis, she and her husband met with Consultant 2 on 23 March 2011. She was told at the meeting that she would be given an appointment to have a CT scan within a few days. She was then given the details of the Cancer Nurse Specialist and was told the nurse would contact her soon.

44. On 28 March 2011 she contacted the Hospital as she had not received an appointment date for the CT scan. However, as her telephone call about this was not returned, she then spoke to the Cancer Nurse Specialist on the telephone the same day. This was the first time she had spoken with her and as the waiting time for a CT scan appointment was up to two weeks, Mrs C said she then telephoned the Hospital again on 29 March 2011 and was told her appointment was scheduled for the next day, 30 March 2011. An hour before her scheduled appointment on 30 March 2011 she was contacted by the Hospital and told that the appointment had to be rearranged. She eventually had the CT scan on 1 April 2011. However, she was not told what would happen next or when she would receive the results of the scan.

45. On 7 April 2011, as she had heard nothing further since the CT scan was performed, Mrs C contacted Consultant 2's office. She said that she was told there was still no report of the scan but that her case was to be discussed at a case meeting the following Tuesday. Mrs C said that when she telephoned the Hospital on 13 April 2011 for an update she learned that such case meetings only took place once a month. Later that day, the Cancer Nurse Specialist contacted her about the results of the CT scan and told her that it appeared that the cancer had not spread outside of the neck area and that it was still at stage 1. She also told her that her surgery was likely to take place on 6 May 2011 or earlier.

46. Consultant 2 then telephoned her on 15 April 2011 and told her that surgery would take place on either 6 or 9 May 2011. Mrs C said that Consultant 2 also told her that the delay in performing the surgery had been due to public holidays and he had been trying to find out if another surgeon could perform the surgery sooner; however, this was unlikely.

47. On 19 April 2011 she contacted Consultant 1, as she had concerns about the delay in starting her treatment. Consultant 1 told her that it appeared from the CT scan that a few lymph nodes were enlarged but the cancer had not appeared to have spread elsewhere. Consultant 1 told her he was surprised about the delay. That same day she was contacted by the secretary of another consultant ENT surgeon at the Hospital (Consultant 3) and an appointment was made for her to see Consultant 3 on 27 April 2011 to discuss her surgery. This was the first time she learned that Consultant 2 would not be performing the surgery. As far as she was aware, Consultant 2 was to have carried out her

surgery unless another surgeon could do so sooner. However, her surgery was still scheduled for 9 May 2011. She heard nothing further from Consultant 2.

48. Mrs C said that she was confused by the sudden change of consultant and felt that from the time of her diagnosis there had been a total lack of communication and a failure to keep her advised about what was happening. It was she who had to keep telephoning the Hospital to find out about both the process which would be followed in relation to the CT scan and also the scan results. Also, the Cancer Nurse Specialist had told her the CT scan had shown no spread of the cancer. However, the Cancer Nurse Specialist later said she was unable to recall speaking to her about this.

49. When she met with Consultant 3 on 27 April 2011, he told her that some 'specks' had been spotted on her lungs during the CT scan but it was unclear what these were. This was the first time she had heard this and contradicted the information she had been given by the Cancer Nurse Specialist and Consultant 1. Consultant 3 had also told her that the cyst was likely to have been connected to the cancer and that she would have to undergo radioactive iodine treatment because the cancer had spread to her lymph nodes and possibly her lungs. Mrs C said she became quite distressed at this news and left the appointment feeling angry, frightened and extremely upset.

50. Despite the above, Mrs C said that whilst in the Hospital for her surgery Consultant 3, his registrar and most of the nursing and support staff had been excellent and very caring.

51. The Board, in response, stated that Consultant 1 telephoned Mrs C on 16 March 2011 to inform her that the findings of the FNA biopsies were 'suspicious' and an urgent out-patient appointment was arranged for the following morning. Mrs C attended the Endocrine clinic on 17 March 2011, in the company of her mother, where Consultant 1 explained the likely diagnosis of papillary carcinoma of the thyroid with spread involving the right sided neck lump. Consultant 1 also explained the anticipated management plan which would involve an urgent referral to his ENT colleague, Consultant 2, for consideration of thyroid surgery. Consultant 1 further explained to Mrs C that if the provisional diagnosis obtained from the FNA biopsies was confirmed at surgery, then she may require ablative radio-iodine at a later date. Consultant 1 also explained to Mrs C that she would need to be monitored long-term in both the Endocrine and Oncology clinics.

52. Consultant 1 wrote to Consultant 2 on 17 March 2011 asking for Mrs C to be reviewed with a view to surgery as, regrettably, cancer of the thyroid was now suspected. Consultant 2 met with Mrs C on 23 March 2011. He explained the importance of ensuring that any patient with possible thyroid cancer was accurately staged by having a CT scan and that treatment options were discussed at the regional Thyroid Cancer Multi-Disciplinary Team meeting. However, the Board explained that this meeting was only held once a month and at that time Consultant 2 saw Mrs C, the monthly meeting had just taken place.

53. The Cancer Nurse Specialist spoke with Mrs C on 28 March 2011 and explained that she would get the CT scan appointment within two weeks of the scan being requested, which was 23 March 2011. The Cancer Nurse Specialist also advised Mrs C that it would then be a further week before the results of the CT scan would be available. She also discussed with Mrs C the probable management plan, as previously intimated by Consultant 1. Mrs C was concerned about the radio-iodine treatment, as she had a young son. Mrs C was, therefore, given written information with regard to this, the Macmillan information booklet 'Understanding Thyroid Cancer'.

54. As the monthly meeting of the regional Thyroid Cancer Multi-Disciplinary Team had just taken place, Consultant 2, therefore, took the opportunity to discuss Mrs C's treatment pathway at the Head and Neck Cancer Multi-Disciplinary Team meeting. This was because some of the clinicians attend both meetings and Consultant 2 wanted to try and escalate Mrs C's treatment as quickly as possible. This meeting took place on 11 April 2011. The lead clinician on Thyroid Cancer was present at this meeting and did not believe that any delay with surgery would adversely affect Mrs C's prognosis. Consultant 2 kept Mrs C informed of progress and contacted her after the meeting on 11 April 2011 to explain things further and to let her know that either he or his colleague, Consultant 3, would be performing her surgery.

55. The Cancer Nurse Specialist advised Mrs C on 13 April 2011, by telephone, that her thyroid cancer had been classed as Stage 1, with a suggestion that she would have a total thyroidectomy and right neck dissection.

56. Consultant 3, who carried out Mrs C's surgery, met with her on 27 April 2011 when he had a fairly lengthy discussion with her regarding her

condition and forthcoming surgery. At that time, he would have advised Mrs C of the exact detail contained within the CT scan report. Mrs C contacted the Cancer Nurse Specialist on 27 April 2011, following her appointment with Consultant 3, as she was very distressed about the possible spread to her lungs and the risk of surgery. The Cancer Nurse Specialist did not recall any conversation with Mrs C about the CT scan results.

Clinical Advice

57. The Adviser noted that the CT scan was performed on 1 April 2011. At this point in time, Mrs C had been seen by Consultant 1 and Consultant 2 in their respective clinics. The Adviser has told my complaints reviewer that he was quite certain that they had explained to Mrs C that the CT scan was crucial for planning the comprehensive nature of her prospective treatment.[2] Surgery was performed on 9 May 2011. In the Adviser's view, the Board's response to this complaint seemed reasonable. The Board had itemised who Mrs C saw and why, what discussions with other colleagues had taken place, such as at the multi-disciplinary team meetings, and emphasised that the time lag between the CT scan and surgery was acceptable as far as Mrs C's overall prognosis was concerned. In the Adviser's opinion, Mrs C had been provided with a reasonable explanation of the process which would be followed, in relation to the CT scan.

58. The Adviser further told my complaints reviewer that he had not seen evidence that Mrs C was given incorrect information about her CT scan results. Furthermore, the Adviser explained that it was important to appreciate that the conclusion of the CT scan was that the significance of the 'tiny nodular lesions … noted in the right upper lobe and both lower lobes' was 'uncertain' and this was of itself inconclusive.

(d) Conclusion

59. The clinical advice that I have received and which I accept is that Mrs C was provided with a reasonable explanation of the process which would be followed in relation to both the CT scan and the scan results.

60. Therefore, I do not uphold the complaint.

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[2] There is a letter from Consultant 2 to Mrs C's GP practice dated 4 April 2011 noting she had been seen by him in his clinic on 23 March 2011 and he had explained to her that she required a CT scan of her neck and chest which Consultant 2 had organised urgently. The clinical records for this date note '-CT scan'.

61. 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

Mrs C	The complainant
Consultant 1	A consultant endocrinologist at Crosshouse Hospital, Kilmarnock
The Hospital	Crosshouse Hospital, Kilmarnock
The cyst	A branchial cyst
ENT	Ear, nose and throat
Consultant 2	A consultant ENT surgeon at Crosshouse Hospital, Kilmarnock
The Board	Ayrshire and Arran NHS Board
The Adviser	A clinical adviser to the Ombudsman
Doctor 1	A specialist doctor in the ENT Department at Crosshouse Hospital, Kilmarnock
FNA	A fine needle aspiration biopsy
CT Scan	A computerised tomography scan
Consultant 3	A consultant ENT surgeon at Crosshouse Hospital, Kilmarnock

Annex 2

Glossary of terms

Branchial cyst	A lump or mass on the neck
Endocrinology	The diagnosis and treatment of diseases related to hormones
Fine needle aspiration biopsy	A diagnostic procedure used to investigate superficial (just under the skin) lumps or masses
Goitre	An enlarged thyroid gland
Graves Disease	An autoimmune disorder that leads to over activity of the thyroid gland
Hyperthyroidism	An overactive thyroid
Papillary thyroid cancer	A type of thyroid cancer
Thyroidectomy	An operation that involves the surgical removal of all or part of the thyroid gland