Management of a man with oesophageal cancer

14HDC00294, 16 December 2016

General surgeon ~ Anaesthetist ~ General practitioner ~ District health board ~ Medical centre ~ Oesophageal cancer ~ CT scan ~ Follow-up ~ Management of referrals ~ Record keeping ~ Rights 4(1), 4(2), 4(5)

A 62-year-old man was diagnosed with oesophageal cancer and underwent chemotherapy and an Ivor Lewis oesophagogastrectomy procedure (surgery to remove the oesophagus and part of the stomach) and had a feeding tube inserted. The surgeon's registrar wrote to the man's general practitioner (GP) noting that there were no further treatment options if the cancer recurred, and that while they did not normally follow up with serial imaging, the GP could get back in touch and request a surveillance scan, which could be arranged at the six- or 12-month mark.

The man's condition began to decline. He attended an appointment with the GP with, among other things, severe constipation and abdominal pain, and requested a scan. The GP sent a request for a CT scan to the surgical clinic at a public hospital. The GP did not provide any information regarding the man's physical symptoms or any assessment findings. Unfortunately, the referral was not actioned by the DHB.

The man reported to the GP that he was waking up with a "sharp burn" at the base of his throat and was experiencing fatigue and shortness of breath on exertion. The GP considered these to be new symptoms that could be attributable to the re-emergence of cancer, but he did not inform the man of this.

At the request of the man, the GP re-sent the CT referral letter. He did not make any additions or amendments to the original request. As there was no indication on the referral letter as to the declining health of the man or of the urgency of the request, the referral letter was left to be reviewed by the surgeon when he returned from leave about a month later. Upon the surgeon's return he sent a request for a CT "to look for recurrent disease".

The man underwent a CT scan. No obvious metastasis was reported, but it was noted that oesophageal distension was indicative of recurrent disease, and follow-up was suggested. Further investigations were undertaken, which indicated a blockage in the man's upper abdomen. The man was scheduled for laparoscopic surgery in order to attempt to unblock his digestive tract, and to confirm whether his cancer had returned. Prior to the laparoscopy, the man had signs of a chest infection including shortness of breath, and underlying acute lung disease.

The surgeon was unable to complete the laparoscopic procedure owing to the distribution of the recurrent cancer. Sadly, the man did not regain consciousness following the procedure and died in the early hours of the morning.

It was held that the GP did not provide sufficient information in the initial referral. Neither did he proactively offer the man the option of private CT scanning or review by the surgeon in private at that stage. Further, the GP did not provide updated information about the man's worsening symptoms in the second referral, discuss the possibility of private referral with the man, or contact the hospital or the surgeon about the delay. Accordingly, the GP failed to provide the man with services with reasonable care and skill, and breached Right 4(1).

Adverse comment was made that the GP did not have a conversation with the man about his symptoms, likely prognosis, and options available to him when he presented with symptoms that were consistent with the return of cancer.

The medical centre did not breach the Code.

Adverse comment was made about the scheduling error by the surgeon, the follow-up arrangements in place after the Ivor Lewis procedure, and that the surgeon did not document the discussion he had with the man regarding the risks and benefits of undergoing laparoscopic surgery.

The anaesthetist's record-keeping was inadequate in a number of areas and, accordingly, it was found that that he breached Right 4(2) for failing to keep clear and accurate patient records in accordance with his professional obligations. Adverse comment was made in relation to the anaesthetist's statement that he did not think that he discussed the risk of perioperative death with the man.

It was recommended that the GP organise an independent GP peer to conduct a random audit of 10 referrals to specialist secondary services that the GP instigated within the last 12 months. It was recommended that the GP attend training on communication and report to HDC.

The DHB's system for management of referrals was inadequate, as the man's initial referral was not tracked sufficiently in order to ensure that triage occurred. Accordingly, it was found that the DHB breached Right 4(5).

It was recommended that, the DHB review the effectiveness of the following measures it implemented as a result of its internal review:

- The criteria and process of follow-up oesophagectomy.
- The plan for communication between cancer support nurses, GPs and specialists.
- The centralised referral process with regard to tracking and triaging of referrals.
- The guidelines for management of communication regarding life-threatening events in the operating theatre.

It was recommended that the DHB report to HDC on the implementation of the remaining recommendations from the internal review.

It was recommended that the anaesthetist undergo further training on record-keeping and report to HDC with evidence of the content of the training and attendance.

It was recommended that the surgeon:

a) Review the effectiveness and appropriateness of his approach taken to follow-up.
b) Review the effectiveness of the written information provided to patients on discharge from hospital.
c) Report to HDC on the implementation of his post-oesophagectomy treatment plan, which he intends to provide to GPs when a patient is referred back into their care.

It was recommended that the GP, the anaesthetist and the DHB each provide a written apology to the man's wife for their breaches of the Code.