Mistaken reporting of condition, and delay in specialist referral in twin pregnancy
(**15HDC00309, 30 June 2017**)

Sonographer ~ Radiologist ~ Registered midwife ~ Radiology service ~ Multiple pregnancy ~ Twin Reversed Arterial Perfusion (TRAP) syndrome ~ Reporting ~ Communication ~Specialist referral ~Rights 4(1), 6(1)

A pregnant woman had a uterine ultrasound scan at a radiology clinic. Her pregnancy was documented as being at eight weeks and six days' gestation. The sonographer documented her impression of a monochorionic/diamniotic (MC/DA) twin pregnancy (one gestational sac with two fetuses). One of the fetuses was reported as having passed away at approximately seven weeks' gestation. The parents were told that the twins were in one sac and that one of the twins had passed away.

A radiologist dictated the formal report and reported that the ultrasound was consistent with a dichorionic diamniotic (DD) twin pregnancy (two gestational sacs). The same radiologist later verified the report.

Later that month, the woman had an obstetric ultrasound performed by a sonographer at a different clinic. The sonographer typed and wrote the formal report, and a radiologist reviewed and signed it off. The formal report for this visit noted twin demise "within the single sac". There was no comparison with the previous report from the first clinic. The word "monochorionic" was not used in the report.

The woman's midwife (Lead Maternity Carer- LMC) did not think that the scan report indicated any change from the previous report.

At 13 weeks' gestation, a further scan was undertaken at the second clinic. The formal report signed off by the radiologist documented that the ultrasound findings indicated that the deceased baby had increased in size.

At the following LMC visit, no discussion relating to the ultrasound scans is documented, and there is no comment regarding any consideration having been given to referring the woman for specialist care.

The following month, the woman had a further scan at the second clinic. The sonographer's antenatal worksheet indicated that the deceased twin had increased further in size, and queried whether this might be due to oedematous changes. Specialist review was recommended. The formal report, signed off by the radiologist, documented these findings.

The LMC sent a referral for a specialist obstetric review based on the advice given in the radiology report.

A further scan was performed at the second clinic. The scan indicated vascularity with umbilical artery flow toward the demised twin, and identified Twin Reversed Arterial Perfusion (TRAP) syndrome. Specialist review was recommended. On the same day, the woman's LMC arranged an urgent referral for review by an obstetrician. Later that month, the woman underwent a Caesarean delivery (at 27 weeks' gestation).

It was found that by failing to report clearly that the woman's pregnancy was monochorionic, the first radiologist breached Right 4(1). The first radiology clinic was not found directly or vicariously liable for the radiologist's breach of the Code.

Adverse comment was made regarding the second clinic's sonographer, for not explicitly using the word "monochorionic" in his report, and for not stating whether this was an MCMA twin or an MCDA twin pregnancy.

By failing to report clearly that the woman's pregnancy was monochorionic, the radiologist at the second clinic was found to have breached Right 4(1), and adverse comment was made that, despite the increase in size of the demised twin at the 13-week scan, the radiologist did not recommend specialist referral.

It was found that a discussion about referral was warranted at the woman's visit to her LMC at 14 weeks' gestation. For failing to recommend to the woman at this visit that a consultation with a specialist was warranted, it was found that the LMC breached Right 6(1). It was also found that the LMC should have appreciated the change in reporting between the first two scans. She should have been alerted, at the very least, to a potential difference in diagnosis, and she should have sought clarification from the radiologist. Accordingly, it was found that the LMC breached Right 4(1).

It was recommended that the two radiologists arrange for a clinical peer review of the standard of their radiology reporting on multiple pregnancies, and provide a written apology to the woman.

It was recommended that the Midwifery Council consider whether a competency review of the LMC was warranted. It was also recommended that the LMC undertake further education and training on the midwifery guidelines and standards, in conjunction with the New Zealand College of Midwives, and provide a written apology to the woman.