Delay in diagnosis of metastatic bone disease
(10HDC00703, 11 September 2012)

District health board ~ Cancer ~ Back pain ~ MRI ~ Communication between providers ~ Diagnosis ~ Rights 4(1), 4(5)

In 2002, a woman had a mastectomy for invasive breast cancer and was advised that she had an 80 percent risk of the cancer recurring within the next five years. She was an outpatient at the Oncology Clinic of a public hospital. She also had a history of chronic regional pain syndrome (CRPS) of the knees.

In 2007, the woman experienced a sudden onset of back pain without suffering any trauma. She was assessed at the Emergency Care Centre of a hospital and an x-ray was taken of her lumbar spine to exclude cancer. The x-ray showed “no bony lesions” and her spine was of normal alignment. As her condition did not improve, she was referred to the General Medical Team the following day.

The General Medical Team assessed the woman, taking into account her CRPS, breast cancer history and normal x-ray. It was determined that her condition was due to “muscle spasm” and she was reviewed by the Orthopaedic Team. Upon review, the orthopaedic registrar considered that she had mechanical back pain and advised analgesia and early mobilisation.

The woman was discharged, and sought ongoing treatment from her GP. She was subsequently seen at Outpatient Clinics by a breast surgeon and an oncologist. Both doctors noted that the woman was doing well but made no reference in the clinical record of her recent hospital admission or that she was experiencing severe back pain.

Three months later the woman was diagnosed with metastatic bone disease.

It was held that there were failures on the part of the General Medical Team in ensuring that the woman’s condition was adequately investigated. In particular, they failed to undertake an MRI or a bone scan in light of the woman’s cancer history and poor response to analgesia. Furthermore, the General Medical Team did not directly communicate with the Oncology Clinic about the woman’s admission.

It was also held that the failures of the General Medical Team were service failures and are directly attributable to the DHB as the service operator. Accordingly, the DHB was found to have breached Rights 4(1) and 4(5).