

Missed diagnosis of hernia and bowel obstruction (10HDC00855, 30 April 2013)

Public hospital ~ District health board ~ Consultant physician ~ Medical registrar ~ Hernia ~ Missed diagnosis ~ Rights 4(1), 4(2), 4(5)

This case concerns the missed diagnosis of a hernia and bowel obstruction over the course of three days, in a patient admitted acutely under the medical team at a public hospital.

A 78-year-old woman was referred acutely by her GP to a hospital on a Thursday with concerns about vomiting and dehydration, an irregular pulse, and a groin lump. The referral contained the previous history and queried the presence of a hernia. The woman was reviewed by a junior medical registrar and a consultant, provisionally diagnosed with an abdominal malignancy, and a treatment plan was initiated. The registrar did not mention the possibility of a hernia and the consultant did not read the referral. No differential diagnosis was documented.

The day following her admission, the consultant was rostered in another town, so the woman was reviewed by the registrar alone. He spoke with the woman's GP, who again queried a diagnosis of hernia and expressed concern that the cause of the vomiting had not been found. The registrar did not inform the consultant of the GP's concerns.

Over the weekend the woman had no medical review for 27 hours, during which time her vomiting continued, and her breathing deteriorated significantly. The woman was diagnosed with, and treated for, community-acquired pneumonia. There was a rapid deterioration in her clinical signs on the Saturday evening, and she subsequently vomited, aspirated, and went into hypoxic cardiac arrest. She was resuscitated, and a later operation confirmed a diagnosis of incarcerated femoral hernia. Sadly, the woman died from the severe hypoxic brain injury she suffered during her cardiac arrest.

The consultant breached Right 4(1) of the Code because he did not take reasonable steps to ensure that he was adequately informed about the woman's history, and failed to consider a hernia as a differential diagnosis.

The registrar breached Right 4(1) because he failed to gather the necessary information and adequately inform the consultant, and he did not seek assistance when the woman's condition did not improve. He also breached Right 4(2) of the Code because his documentation did not meet professional standards.

The district health board failed in its duty to provide an appropriate standard of care to the woman and breached Right 4(1). In addition, the DHB breached Right 4(5) of the Code, because poor documentation and handover by staff resulted in a failure to ensure the woman received quality and continuity of services.