Missed diagnosis of lung cancer
(07HDC08819, 6 May 2008)

Public hospital ~ District health board ~ Lung cancer ~ Diagnosis ~ X-ray ~ Radiology reporting ~ Communication ~ Handover ~ Open disclosure

A 68-year-old man went to an emergency department at a public hospital because of a bowel obstruction. He was admitted to hospital, but his bowel problem resolved and he was discharged four days later. A surgical registrar had noticed an abnormality on his right lung on a routine chest X-ray taken when the man was examined in the emergency department, but the X-ray was not formally reviewed and reported on by a radiologist until three months later. The radiologist confirmed that there was a mass on the right lung, "suspicious for central carcinoma". He did not notify anyone of this significant, unexpected abnormality and it was never reported to the man or his general practitioner. Three years later the man returned to hospital with severe pneumonia and was diagnosed with inoperable advanced lung cancer.

It was held that the man's lung cancer should have been detected so that appropriate treatment could be offered. The three-month delay in radiology reporting, and the lack of follow-up was unacceptable.

The DHB made significant improvements in radiology reporting, with additional staff and electronic reporting and sign-off, and in the handover of clinical information. The board acknowledged its mistake, undertook a full review, shared the findings with the family, and offered an unreserved apology. Its honest and open approach, and support for the family, was commendable, and no further investigation was undertaken.

This case highlights problems in handover of clinical information and delays in radiology reporting which are not unique to this hospital, and highlights the challenge faced by New Zealand hospitals to ensure that all patients receive health care they can rely on.