# Lesion missed on X-ray
# (14HDC01066, 5 August 2016)

*Radiologist ~ Radiology service ~ X-ray ~Lytic lesion ~ Bone destruction ~ Missed diagnosis ~ Right 4(1)*

An older woman presented to her general practitioner (GP) with a 10-day history of severe pain in her lower back and hips. The GP referred the woman for a lumbar spine (lower back) X-ray. The X-ray was reported by a radiologist at a private radiology service. The radiologist identified multilevel chronic disc degeneration, but did not detect an L2 lytic lesion.

At the time of the events, the radiology service was understaffed, and the radiologist had an injury which slowed down the speed of his work. The radiology service attempted to arrange a work place assessment for the radiologist, but, in the interim, his workload remained the same.

The woman continued to experience pain, and her mobility decreased. She sought assistance from a number of different services over the next eight months and was subsequently admitted to the local hospital. An X-ray and magnetic resonance imaging identified an L2 lytic lesion, as well as significant spinal cord compression. The woman was transferred to a larger public hospital where she was diagnosed with multiple myeloma (cancer of plasma cells) and underwent spinal stabilisation surgery. Her recovery was difficult, and she was transferred back to the local hospital. The woman developed hospital-acquired pneumonia, and her condition began to deteriorate. She died a short time later.

It was held that the radiologist did not provide services to the woman with reasonable care and skill, as he failed to identify an L2 lytic lesion on the woman's X-ray. Accordingly, he breached Right 4(1).

Adverse comment is made that, at the time of these events, the radiology service was understaffed in that it did not have a sufficient number of radiologists working. Adverse comment is also made that, although the radiology service attempted to arrange a work place assessment with regard to the radiologist's injury, nothing more was done in the interim to ensure that the radiologist could continue to carry out his work appropriately.

The care the woman received from the local DHB was appropriate in the circumstances.

It was recommended that the radiologist have an independent radiologist peer perform a review of a random selection of his reports completed in the last 12 months, and that he provide a written apology to the woman's husband.

It was recommended that the radiology service review the effectiveness of the changes it has made as a result of this case. This includes an update on the progress of the radiology service's plans to decrease interruptions to radiologists from technicians for advice, by reviewing its computed tomography (CT) and magnetic resonance imaging (MRI) protocols, and to reduce the time radiologists need to spend on vetting referral requests, by considering changing this to an electronic process.