Manitoba
Health, Seniors and Active Living

Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

All Results from Diagnostic Imaging Not Addressed

Summary:

A patient had a cancer removed from their cheek. Five months later, a follow up CT scan showed a thickening of the cheek. The surgeon ordered a PET scan to rule out any further disease. The PET scan showed four findings. Only one finding was noted in the patient's chart: "asymmetric metabolic activity in the region of left base of tongue/tonsil". The fourth finding listed on the report “A concerning finding of significant metabolic activity in the uterine cavity” was not addressed.

Two months later, the patient was experiencing post-menopausal bleeding. The patient’s family physician referred the patient to gynecologic oncology. The patient was assessed. The case was discussed at the disease site group conference. A decision was made to perform an exam on the patient under general anesthesia and then to consider and discuss treatment options with the patient.

A biopsy was performed. The pathology showed invasive adenocarcinoma of the cervix/endometrium. The patient was admitted to hospital due to various complications relating to the disease.

If the gynecological findings from the PET scan had been addressed, the patient could have been treated sooner and may not have had the complications from this locally advanced disease.

Keywords:

Referral, communication

Findings of the Review:

The patient's post-menopausal bleeding started prior to the cheek cancer diagnosis. The patient had an abdominal CT scan that showed "no etiology for the patient's hematuria". She was then referred to an urologist. However, the bleeding stopped prior to her appointment with the urologist so the patient cancelled the appointment.

According to the surgical team who ordered the PET scan, an assumption was made that the patient was seeing a different physician for hematuria and therefore their physician would follow up on the results of the PET scan.

Typically this finding on the PET scan would be addressed by sending a referral to the gynecologic -oncology group or a follow up ultrasound would be performed. In this case, neither intervention was completed.

According to documentation in the patient's chart, the note referring to the PET scan only referred to the results relating to the suspected cheek recurrence. Nothing was recorded related to the gynecological findings. All findings should have been noted in the chart. According to the College of Physicians and Surgeons of Manitoba Standards of Practice of Medicine, the ordering physician is ultimately responsible for any results from a diagnostic test.

System Learning:

The surgeon assumed that more physicians were involved in the patient's care and would be aware of the results of the PET scan.

At the facility where this originated, a field will be added to all image test requisitions to carbon copy the family physician on the results.

This event will be shared with the Standards Committee so that learning and improvement to clinic practices can occur.

Date of Posting: February 2019